CREDIT CARD PAYMENT FOR THERAPY FEE

(PLEASE COMPLETE ALL FIELDS)

DATE: _____

NAME: _____

Address information associated with credit card:

ADDRESS: _____

CITY/ST/ZIP:_____

EMAIL ADDRESS: _____

PHONE: _____

AMOUNT:_____

NAME ON CARD: _____

TYPE OF CARD: _____

CARD NUMBER: _____

EXPIRATION DATE: _____

3-DIGIT SECURITY CODE: _____

I agree to have my credit card charged for the appropriate fee for each of my therapy sessions until I notify Cynthia Gallagher, MFT, otherwise.

_____

Signature

_____

Printed Name