711 Berne St SE – Unit C | Grant Park, Atlanta, GA 30312| phone: 404-914-0279 | parksidepsychotherapy.com

CREDIT CARD PAYMENT RECORD

Client Name as it Appears on Card: _____

Card Number: _____ Expiration Date: _____

Credit Card Billing Information: _____ _____ _____
Street Number Zip Code Security Code

Security Code on Card (3 or 4 numeric digits): _____

Client Signature: _____
Signature indicates that you agree to allow your therapist to make charges on your card without you present.

Therapist's Name: _____

Description of Service (e.g., 90847)	Date of Session	Date Posted	Amount Posted	Authorization Code	Recorder's Initials