CREDIT CARD AGREEMENT

Please complete your credit card information below. By providing this information it will simplify payment procedures for credit card payments and in the event of a missed appointment without cancellation. By signing this agreement, your account will always be current.

Type of Card:

❑ Visa ❑ Master Card ❑ Discover Card

Attached to health spending plan? ❑ Yes ❑ No

Card Number: _____

Expiration Date: _____/_____ (MM/YYYY)

Security number on Card: _____ (3 digits on back of card)

Name on Card: _____(please print clearly)

Address of Billing Address for Card:

_____
Full Street Address or P.O. Box

_____
City State Zip code

Phone Number: _____

By signing below, I authorize **Brenda Price, LCSW-C**, to charge my credit card for services rendered or for missed appointment fees:

_____ _____
Signature Date