

**Marty Simpson, LMFT, CSAT, CDWF**

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**CREDIT CARD AUTHORIZATION**

I, \_\_\_\_\_, authorize Marty A. Simpson, LMFT to keep my signature on file and to charge my credit card in the amount of \$ 230.00 as payment for: each 50 minute psychotherapy or neurofeedback session (prorated for longer sessions at the same rate/hour).

\_\_\_\_\_ VISA      \_\_\_\_\_ MASTERCARD      \_\_\_\_\_ AMERICAN EXPRESS

PATIENT NAME: \_\_\_\_\_

NAME ON CARD: \_\_\_\_\_

\_\_\_\_\_  
CREDIT CARD ACCOUNT NUMBER

\_\_\_\_\_  
EXP DATE

\_\_\_\_\_  
3 or 4 digit CCV

\_\_\_\_\_  
BILLING ADDRESS

\_\_\_\_\_  
ZIP CODE

\_\_\_\_\_  
EMAIL (REQUIRED)

\_\_\_\_\_  
CARDHOLDER SIGNATURE

\_\_\_\_\_  
DATE