

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 \$ 200.00 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