Credit/Debit Payment Authorization

Nicole Bessire-Taylor, M.A., LMFT 46572
216 N. Glendora Ave., Suite 210 Glendora, California 91741

This is to certify that I give permission to keep my credit/debit card information within my clinical file to render payment for services as services are rendered. Payments will be made to Nicole Bessire-Taylor, M.A., LMFT.

Card Type: _____
Name on Card: _____
Card Number: _____ Expiration Date: _____
Security Code: _____ Billing Zip Code: _____

If you would like a text or emailed copy of the receipt, please indicate:

_____

It is the clients responsibility to notify the clinician of any changes to credit/debit information in order to maintain timely payment for therapeutic services.

I, _____, have been informed and understand to my satisfaction, the above mentioned policy and hereby concur to the terms and conditions of this agreement.

_____ _____
Client Signature (Client's Parent/Guardian if under age 18) Today's Date