BITA TEBYANI, PSY.D
Clinical and Forensic Psychologist PSY 27881
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Beverly Hills, California 90211
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drbitatebyani@me.com

PAYMENT AUTHORIZATION

I,

_____

Cardholder's Name

at

_____

Cardholder's Street Address, City, State, Zip & Phone Number

Hereby authorize Bita Tebyani, Psy.D for charge(s) to the credit card below for Psychological services rendered and will not dispute the charge(s) with my credit card company.

Client Name (if not cardholder):

_____

Credit Card Information

Type of card: American Express ☐ MasterCard ☐ Visa ☐ (please check one)

Credit Card Number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Expiration Date: Month/Year: ___ - ____

CVC code: _____

X

_____ _____

Cardholder's Signature Date