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PERMISSION TO USE CREDIT CARD

Patient Name: _____

By signing this form, I agree to have my credit card charged for services for the patient listed above at the time of service, including charges for missed sessions that are not cancelled within 48 hours prior to the scheduled appointment.

Name on Card: _____

Billing Address: _____

Card Number: _____

Expiration Date: _____

CVC Code: _____

Signature: _____

Today's Date: _____