Dee-Anna R. Bradley, Psy.D., LMFT, LPCC

319 Main Street, Suite 5

Placerville, CA 95667

530-391-9976

**CREDIT CARD AUTHORIZATION**

I hereby authorize any co-pays, non-insurance covered incidental charges (i.e. late cancellation/no-show fees) to be charged to the credit card listed below.

Client/Guarantor initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this form is required for any treatment provided by Dee-Anna Bradley, Psy.D., LMFT, LPCC. I agree to keep this form update and inform Dr. Bradley of any changes.

Client/Guarantor initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code on back of the card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code associated with card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature authorizing payment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_