Credit Card Information

Name as it appears on the card____

Mastercard ____ Visa____ FLEX or HSA______

Credit Card Number____

Code on back_________

Expiration Date___________________________

Billing Address for the Card____

I, ____________________, do hereby give Toni A. Nicolsen, LMFT permission save my card information to electronic health records and to charge my credit card for therapy services rendered.

Signature____