

Credit Card Authorization Form

Name: _____
Phone: _____
Email: _____

I authorize Dr. Kim Farber, LMFT to charge the following credit card for fees for services and/or fees for sessions cancelled less than 48-hours (2 business days) in advance.

Credit Card Type:
 Visa
 Mastercard
 Amex

Name on Card: _____

Credit Card #: _____

Expiration Date: _____

Security Code (3 digits on back of Visa & Mastercard - 4 digits on front of Amex): _____

Billing Street Address: _____

Billing City, State, Zip: _____

Signature: _____

Date: _____