AUTHORIZATION TO USE CREDIT CARD FOR BILLING:

I ask that you pay for sessions/consultation with the use of a credit card, either Mastercard, Amex or Visa. If you have any questions feel free to contact me at 413-519-1788 or amandarobertsphd@gmail.com

Thank you!

Name:

_____

Credit card number: _____

Expiration Date: _____

CVV Code: Please give this to me verbally to protect privacy

Please Circle: ◯ Visa ◯ Mastercard

Name on card (please print)

Billing Address: _____

Standing payment agreement: I authorize Dr. Roberts to charge to my card after each session until the end of treatment or consultation.

Signature: _____ date: _____