

*Studio For Change*TM

Client Credit Card Payment

Type of Card (check one): Visa MasterCard Discover

Name on Card (please print): _____

Card Number: _____

Expiration Date: _____ Three Digit Security Code (on back): _____

Billing Amount: _____

Card Holder's Billing Address:

Street

Apartment, Suite #

City

State

Zip Code

Card Holder's Signature

Today's Date

I hereby understand that this credit card information is to remain on secure file with Studio For Change until the termination of treatment; All treatment charges will be billed with this credit card unless I request otherwise _____ (Card holder's initials)

Name of Treating Therapist: _____