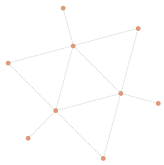

DEBORAH C. WEISBERG

LMFT, LPCC

Credit Card Authorization

I, _____ (name as it appears on credit card), authorize the use of my credit/debit card described below for charges related to services provided by Deborah Weisberg, LMFT, LPCC, including:

○ Payment for my sessions in the amount established by my provider: _____ (fee per session).

○ Payment for a no-show or missed session without 48 hours notice.

○ Payment for a phone or telehealth session.

○ Payment for past due sessions.

I understand that the amount charged on my card will be reflected on my credit card statement and that "Deborah Weisberg, LMFT, LPCC" (or an abbreviated version) will appear on my credit card statement. _____ (Initial)

I agree that this form is valid for the length of therapy and authorization for the use of this card will be canceled at the termination of therapy. _____ (Initial)

Client's Name: _____

Card Holder's Name: _____

Card Holder's Billing Address:

Street: _____ City: _____ State: _____ Zip: _____

○ Visa ○ MasterCard ○ American Express

Card number: _____ CVC# (3-digit code on back of card): _____ Exp. Date: _____

Signature of Card Holder: _____ Date: _____