Felita W Fox, MFT # MFC45634
690 W Fremont Ave. 9D
Sunnyvale, CA 94087

Credit Card Payment Form

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

Client Name _____
First Middle Initial Last

I authorize Felita Fox to charge my card for professional services as follows:

Initial
____ This visit only, for the amount of _____.

____ Recurring charges, date(s) of service ____/____/____ to ____/____/____

Monthly biweekly weekly per visit

Card Type (circle one): Visa, MasterCard, Discover or American Express

Expiration Date: _____ Credit Card #: _____

Verification/Security Code: _____

Name as Printed on Card: _____

Billing Address: _____

City: _____ State: _____Zip: _____

Signature: _____Date:_____

I understand if I do not notify her of my inability to attend a scheduled therapy appointment, do not cancel my appointment at least 24 hours in advance as agreed to in the Cancellation and Failed Appointment policies stated in the signed Informed Consent Form. I will be charged the full session fee.

Signature: _____ Date: _____