

Alycia Williams, MS, LPC

5230 E. 69th Place Tulsa, OK 74136
918-519-0583

Credit Card Authorization

DATE: _____

Client Name: _____ Date of Birth: _____

Address: _____ Zip Code: _____

Credit Card: Visa – Master Card – Discover – American Express – Discover
Card Number: _____ CVV: _____

Expiration Date: _____

Cardholder Name: (as listed on card) _____

I authorize Alycia Williams, MS, LPC to charge psychotherapy session fees to this credit card. I understand that if for any reason this charge is not accepted I will be responsible for payment of the services. I also understand that if I fail to attend a scheduled therapy session and do not provide 24 hours notice my credit card will be charged for the session fee.

I attest that I am authorized to use this credit card. If for any reasons this card is no longer valid I will inform provider at time of service.

Cardholder/client signature: _____ Date: _____