NADYA L.K. TILLUCKDHARRY, PSY.D., LLC

CREDIT CARD AUTHORIZATION

CLIENT NAME: _____ D.O.B.: _____

Cardholder Name: _____

Cardholder Signature: _____

Billing Address: _

_____

_____

Billing Zip Code: _____

Credit Card Type: _____VISA _____MASTERCARD _____DISCOVER _____AMEX

Credit Card #: _____-_____-_____-_____ Expiration Date: _____/_____

Card Identification # (last 3 digits located on the back of VISA and MASTERCARD/ 4 digits for AMEX): _____

I agree to allow Dr. Tilluckdharry to charge current and future invoice balances to this credit card. I understand that I am responsible for any unpaid balance. I have read and understand Dr. Tilluckdharry's fees for service and cancellation policy. I agree to have any current and future unpaid fees charged to the card listed above.

_____ _____

Parent / Legal Guardian Date