

Megan Torrey-Payne, LCSW

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LCS 21970

Credit Card Authorization

I authorize Megan Torrey-Payne, LCSW to keep my credit card information and signature on file. Charges will only be made to my card for the following reasons:

- **Appointments attended.** (If this is my intended payment method.)
- **Insufficient funds / returned checks.**
- **Charges for missed appointments.** (Appointments cancelled with less than 24 hours notice or no shows will be billed the full fee for the session missed as laid out in the Therapeutic Contract and agreed to by the Client in the Consent Agreement.)
- **Balances of charges not paid by me or my insurance.**

I understand that this information will be destroyed 30 days after our last contact. I may revoke this agreement at any time by providing a request in writing.

Client Name _____

Card Holder's Name _____

Card Holder's Address _____

City _____ State _____ Zip _____

Card Holder's Email _____

Account Number _____

Expiration Date _____ Security code _____

Visa

American Express

MasterCard

Discover

Signature _____