## <u>Teresa DeAnn Langley LPC, LLC</u> <u>www.capaoga.com</u> •,(404) 904-2805 • deannlangleylpc@hushmail.com

## CREDIT CARD AUTHORIZATION AND PAYMENT RECORD

Client Name as it Appears on Card	;			
Card Number:	Expiration Date	Expiration Date:		
Credit Card Billing Information:	Street Number	Zip Code	Security Code	
Client Signature:				
NOTE: Your signature indicates your a  o You authorize your therapist to o You authorize your therapist to	o maintain your card informa	tion and make charges witho	, .	

- encrypted or physically secured.

  O Your Credit Card will be automatically charged for any missed appointment / late cancellation fees.
- Any updates to card info will not affect your authorization. Your authorization will remain in effect until revoked in writing.

Therapist's Name: Teresa DeAnn Langley, LPC

<u>Description of Service</u> (e.g., 90847)	Date of Session	<u>Date</u> <u>Posted</u>	Amount Posted	<u>Authorization</u> <u>Code</u>	<u>Recorder's</u> <u>Initials</u>

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