

Sonja Harrison, LICSW  
1555 Connecticut Avenue NW, Suite 2E  
Washington, DC 20036  
202-601-3200 (P) 202-697-5032 (F)

**Credit/Debit Card Authorization**

Should I choose to provide a credit (or debit) card account number, I agree to allow for all payments, insurance copayments, and missed appointment fees to be billed to my credit card.

This card number and my signature will be kept on record, and any unpaid balances will automatically be paid by this card without prior notification.

Client's Name:

\_\_\_\_\_

Name of Cardholder (as it appears on card):

\_\_\_\_\_

Credit Card Billing Address (the address that the credit card statement is mailed to):

Address Line 1:

\_\_\_\_\_

Address Line 2:

\_\_\_\_\_

City, State, Zip Code:

\_\_\_\_\_

Credit Card Type:     Visa     Mastercard     American Express     Discover

Credit Card Number:

\_\_\_\_\_

Expiration Date: \_\_\_ / \_\_\_

Security Code: \_\_\_\_\_

I authorize my card account to pay fees due to Sonja Harrison, LICSW.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_