# Crystal Glenn, MA, LPCC

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## Credit Card Authorization

*Accepted Credit: Visa and MasterCard only*

| |
|---|
| Name on Card: |
| Credit Card Number: |
| Expiration Date: |
| CSC (Last 3 digits on back of Visa and MC): |
| Billing Address (Including Zip Code): |
| |
| Therapist Name: Crystal Glenn, LPCC |
| Date of Service: Any for which payment is not received from you or your insurance company |
| Description of Product/Service: Initial Assessment, Individual Session, Cancellation Fee, Phone Counseling, Records Request, Forensic Consultation |
| Amount Charged: Per Office Policies listed in Client Agreement and Informed Consent form |

By signing below, you verify the above information is accurate and you give Crystal Glenn permission to charge your credit card for any unpaid balances and fees associated with your services.

Client Name: _____
(If different from the cardholder)

Cardholder Signature: _____ Date: _____