

**Karen Pickett, LMFT
Licensed Psychotherapist CA MFC40735
EIN# 84-1685910**

Client Information

Name:

Address:

City:

State:

Zip Code:

Date of Birth:

Primary Phone Number:

Alternate Phone Number:

Email:

Referred by:

Current Medications and Dosages:

Emergency Contact Name:

Relationship to you:

Emergency Contact Phone Number:

Primary Reason for Seeking Therapy:

**Karen Pickett, LMFT
Licensed Psychotherapist CA MFC40735
EIN# 84-1685910**

Credit Card Authorization Form

You must maintain a valid credit card on file with me to be used in the following circumstances:

1. Payment for sessions and other services
2. You cancel an appointment with less than the required 48-hour notice
3. You fail to show up for a scheduled appointment

I accept the following types of credit cards: Visa, MasterCard, AmEx.

Please complete the following information which will be used to process your payment:

Name on Card:

Billing Address:

City:

State:

Zip Code:

Country:

Card#:

Exp Date:

Security code:

By signing below, I am authorizing this credit card to be charged per the above.

Signature:

Date: