Swanson, Conti & Associates

A Psychological Corporation
818.986.9666
www.SwansonContiAndAssociates.com
16311 Ventura Boulevard, Suite 925
Encino, California, 91436

Permission to Use Credit Card to Bill for Services

Please complete this form to have your credit card added to your file. Your credit card will only be billed/processed for services after such services have been rendered (*Unless otherwise agreed to in writing*).

Type of Card: ☐ Visa ☐ Mastercard

☐ American Express ☐ Discover

Name on Credit Card: ________________________________

Credit Card Number: ________________________________

Expiration Date: _____ / _____ **Security Code:** _________

By signing below, I give Swanson, Conti & Associates ("SCA") permission to bill my credit card for any and all services ("Services") my family or I have received after such Services have been provided. I acknowledge that I have been given a Fee for Service Schedule ("FFS") before the beginning of treatment and I understand that any and all charges will be billed in accordance with the FFS. Furthermore, understand that a fee of $10.00 will be applied for all credit card transactions completed.

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Signature of Cardholder Date