Valerie Hyatt-Martin, LCSW-S
602 Strada Circle, Suite 122
Mansfield, TX 76063

Credit/Debit Card Payment Consent

Client name:_____

(Card holder) Name on card if different than client_____

Card Number_____

Expiration Date_____ Security Code_____

I authorize Valerie Hyatt-Martin, LCSW to charge my credit/debit/health account card for professional services (insurance co-pays or agreed upon amount for sessions). I verify that my credit card information, provided above, is accurate to the best of my knowledge.

Client initials: ____

Card holder Initials (If different than client)_____

Date:_____

Signature:_____