Indianapolis Trauma Therapy Center

Trauma and Attachment Therapy
Psychotherapy, Consultation, Training

Authorization to Charge Credit Card/Health Savings Card

Card Type: (Circle one) MC/Visa Card Number________________________________

Expiration Date: ______________ Security Code: ______ Zip Code: ________________

Name as it appears on the card ____

Patients/clients, other than cardholder, that may be charged to this credit card:

Name ____ DOB __________________________

Name ____ DOB __________________________

Name ____ DOB __________________________

Name ____ DOB __________________________

Name ____ DOB __________________________

Name ____ DOB __________________________

I, ____, authorize Indianapolis Trauma Therapy Center to charge my credit/debit/health savings card for psychotherapy sessions, late cancellations, missed sessions, and other services rendered for the above noted patient(s)/client(s).

Authorized Signature of Cardholder _______________________________________Date ____________