Lindsay A. Solomon, Psy.D., LLC
Licensed Psychologist

Credit Card Authorization for Services Rendered

I hereby authorize Lindsay A. Solomon, Psy.D., LLC, to keep my credit card on file and to charge my credit card for all services rendered, including psychotherapy sessions or appointments not cancelled with 24 hours advanced notice (following the first such missed appointment, per consent for treatment agreement). I understand that this form is valid for 1 year unless I cancel the authorization in writing.

Credit card billing information:	
Name:	
Email Address:	
Credit card type:	❑ Visa ❑ MasterCard ❑ American Express
Credit Card #:	
Enter CVC #:	For Visa and MasterCard, the last 3 digits on back of card: For American Express, the 4 digits on face of card:
Expiration Date:	
Billing Address:	
City:	
State:	
Zip Code:	
Phone Number:	

Authorized Signature:	Date: