Credit Card Authorization Form

For Payment of KCM Therapy LLC Fees

NOTE: Please fill out completely, sign the bottom, and email or mail to my office.

Name:

Credit Card Billing Address:

Credit Card Type

Visa

MasterCard American Express

Card Number:

Expiration Date:

CC Verification Number on card:

Name on Card: Payment Amount: SDLLP Invoice Date:

(V/MC on back) (AMEX on front)

I hereby authorize the above payment on my credit card as set forth above.

SIGNATURE _____

Send signed agreement to:

KCM Therapy LLC

c/o Karen Mitchell, LCSW

776 Mountain Boulevard, Warren, NJ 07059