IT IS REQUIRED THAT ALL PATIENTS PUT A CREDIT CARD OR DEBIT CARD ON FILE. THIS MUST BE COMPLETED PRIOR TO THE FIRST SESSION.

NAME: _____ DATE: _____

CREDIT CARD NUMBER: _____

EXP. DATE: _____

I AUTHORIZE THAT MY CREDIT CARD MAY BE CHARGED BY WOMEN'S THERAPY CLINIC AUTOMATICALLY FOR ANY SESSION I DO NOT ATTEND WITHOUT GIVING 24 HOURS NOTICE.

SIGNATURE: _____