DR. SHEILA KHALEGHIAN

CLINICAL PSYCHOLOGIST

CREDIT/DEBIT CARD AUTHORIZATION FORM

Client Name: _____

Name on Credit Card: _____

Cardholder's Phone Number: _____

Type of Card: (Credit / Debit / HSA)

Credit Card Number: _____

Expiration Date: _____ CVV #: _____

I, _____, authorize Sheila Khaleghian, Psy.D. to bill my credit card for any ongoing balances on my account.

_____ _____

Signature of card holder Date

_____ _____

Signature of client (if different from card holder) Date

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