CREDIT CARD AUTHORIZATION

Please complete all information on this form to authorize us to accept your credit card.

I, _____hereby authorize Melissa Richman, Psy.D, LCSW A Psychotherapy Corporation and Licensed Clinical Social Worker ("Dr. Richman"), to charge my credit card for her professional services, as follows:

Please circle card type: MasterCard / Visa / American Express

Card Number:_____

Expiration Date: Month _____ Year _____ Security Code _____

Authorized Amount $_____

I agree that this is a standing authorization, and this amount may be charged to my card for each appointment I make with Dr. Richman. The amount charged may change from time to time, in keeping with Dr. Richman's then current hourly rate.

Card Owner Billing Address:

_____

_____

Billing Zip Code _____

Signature: _____

Printed Name:_____