TAMARA WADE LCSW

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Credit Card Authorization Form

I _____give my permission for Tamara Wade LCSW to charge the following credit card for services rendered as agreed upon in the consent for treatment. In addition I understand that if I do not cancel within 24 hours of my session appointment, a full session charge will be processed on the card below.

_____ _____
Signature of Card Holder Date

Visa Mastercard American Express Discover

CARD NUMBER: _____

SECURITY NUMBER (CRV): _____

EXPIRATION DATE: _____

NAME ON CREDIT CARD: _____

BILLING ADDRESS: _____

PHONE NUMBER: _____