Lital Diament, MA, LMFT (LMFT 96310) (818) 519-2815

ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted:

☐ Visa ☐MasterCard ☐Check

Service fees will be deducted from the designated account at the time services are rendered.

Client Information:

_____
Client Name Date of Birth

_____
Address

_____
City State Zip Code

_____
Home Phone Cell Phone

Cardholder Information:

_____
Name

_____
Address

_____
City State Zip Code

_____
Email

I authorize any service fees to be deducted from the credit or debit card indicated below:

_____
Signature Date

Credit/Debit Card Information:
Please provide your payment information below.

Card Type (check one): ☐Visa ☐MasterCard

_____
Card Number Security Code (three digits on back of card) Exp Date