Gail A. Phillips, LCSW

2734 N. Hills Drive NE
Atlanta, Georgia 30305
gail@gailphillips.net
(404) 982-9010

Credit / Debit Card Authorization

Client Name _____
(Parent/Guardian if Minor Client)

Name as shown on card (please print) _____

Type of Card: VISA MASTERCARD AMERICAN EXPRESS DISCOVER DEBIT

_____ _____ _____
Credit/Debit Card Number Exp Date (MM/YY) Security Code

Billing Address _____

_____

Email Address for Receipt _____

Please note: Credit/Debit card payments are processed on a weekly basis. An insurance receipt will be emailed to you.

By signing this you:

- authorize Gail Phillips, LCSW to charge your credit or debit card.
- agree to allow charges to be made on your card without you present.
- **understand that you will be charged a $5.00 processing fee per transaction.**
- agree to be bound by the terms set forth in the Cardholder's Agreement.
- understand that you will be charged for missed appointments and late cancellations.

_____ _____
Signature Date