Gail A. Phillips, LCSW

gail@gailphillips.net ~ www.gailphillips.net
2734 N. Hills Drive, Atlanta, GA 30305
(404) 982-9010

Credit or Debit Card Agreement

Client Name: ____

____
Print name as shown on card

Type of Card: VISA MASTERCARD AMERICAN EXPRESS DISCOVER DEBIT

Card Number: ____

Expiration Date: ____________________________ Security Code: ______________________________

Billing Address: ____

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By signing this you:

- understand that you will be charged $6.00 per appointment for processing my card.
- authorize Gail Phillips, LCSW to charge your credit or debit card.
- agree to allow charges to be made on your card without you present.
- 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 (less than 24 hrs.).

Please sign indicating that you agree with the above statements.

____ Date: _____________________
Signature as shown on card