Core Discovery Counseling, Inc.
3565 Piedmont Road, Suite 510 Atlanta GA 30305 kimmtaff@gmail.com www.ktafftherapy.com

CREDIT CARD PAYMENT RECORD

Client Name as it Appears on Card: _____

Card Number: _____ Expiration Date: _____

Credit Card Billing Information: _____ _____ _____
Street Number Zip Code Security Code

Security Code on Card (3 numeric digits): _____

Client Signature: _____

Signature indicates that you agree to allow your therapist to make charges on your card without you present.

Therapist's Name: _____

Description of Service (e.g., 90847)	Date of Session	Date Posted	Amount Posted	Authorization Code	Recorder's Initials

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