Magill Psychotherapy, LLC
2011 Commerce Dr N F109 Peachtree City GA 30269
1720 Peachtree St NE 510 Atlanta GA 30309
404-953-5279
www.magilltherapy.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 on Card (3 or 4 numeric digits): _____

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

****CREDIT CARD WILL BE CHARGED $____50.00____ FOR MISSED APPOINTMENTS AND APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS OF SET APPOINTMENT TIME****

Therapist's Name: ____Kara Magill, LCSW_____

Description of Service (e.g., 90837)	Date of Session	Date Posted	Amount Posted	Authorization Code	Recorder's Initials