YOUR FAMILY THERAPIST
DONNA TOUFER BERNS LMFT, DCH
LICENSED MARRIAGE AND FAMILY THERAPIST
DOCTORATE OF CLINICAL HYPNOTHERAPY
WWW.YOURFAMILYTHERAPIST.COM
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CREDIT CARD INFORMATION CANCELLATION

As per the signed agreement on the Informed Consent, your credit card number will be kept on file in a secured and locked location strictly for purposes of charging your full regular cancellation fee per missed session. Charging your card for this amount is only necessary should you not give 24- hours' notice that you are unable to keep your appointment.

Please circle type of card: VISA Master Card American Express

Name of Cardholder:_____

Credit Card Number _____ExpirationDate:_____

Security Code: _____ Zip Code: _____

Signature of Cardholder: _____

AUTHORIZATION FOR USE OF CREDIT CARD

If you prefer, your credit card on file can also be used to charge your regular future sessions. By signing below, you acknowledge your consent to the agreed upon.

Signature of Cardholder: _____