**Cristi Thielman, MS, LMHC**
180 Nickerson St
Ste. 303
Seattle WA 98109
(206) 352-3752
www.cthielman.com

## Credit Card Authorization Form

Client Name:_____ Date of Birth:_____

This document authorizes Cristi Thielman, MS, LMHC to automatically bill the credit card below for charges associated with treatment for the client named above. Charges will be made to the credit card on or after the date(s) of service and will include only those services contracted. Additional services will be billed only as mutually agreed upon.

Card Type: ☐ Visa ☐ Mastercard ☐ American Express

Card Number:_____ Expiration Date:_____

Name on Card:_____ Security Code:_____

Billing Address:_____

City:_____ State:_____Zip Code:_____

This credit card information will be stored in a locked file cabinet and/or in HIPAA compliant billing software. I understand that the billed services will be subject to the parameters described in Cristi Thielman MS, LMHC Disclosure Statement and I have received a copy of and understand these policies.

_____ _____

Signature of Cardholder Date