SARA MATHEWS DIXON
Psychotherapy

SMD Associates, LLC.

Credit Card Information

Name on Card:_____

Type of Card: Mastercard Visa American Express Discover

Card Number:_____

Expiration Date: _____ CVV Code:_____

Zip Code: _____

Policy

This card will be kept on file and only charged in two instances:

1. You have verbalized that this is your preferred form of payment and consent to the card being charged after each session.
2. You do not cancel your scheduled session per practice policy, i.e., within 24 hours of the session time.

I have read and understand the above policy.

_____
Print Name

_____ _____
Signature Date