Susan Berlin & Associates

Credit Card Authorization Form

Please provide all the information requested below as a form of payment for psychotherapy & other charges in working with *Susan D. Berlin, LICSW, CASAC* at:

Susan Berlin & Associates
1054 31st Street, NW, Suite 500, Washington, DC 20007

Cardholder Information

Name as it appears on the credit card: _____

Card type: ❑ Visa ❑ MC ❑ Amex

Credit Card Account Number: _____ Exp. date: _____

Security Code _____

Credit Card Service Fee (Initial for approval of fee): 4% MC/VISA _____ 4% AMEX _____

Address:
(where statement is mailed) _____

City, State and Zip: _____

Phone Number: _____

Email Address for Receipt: _____

I certify that all information is complete and accurate. I hereby authorize Susan Berlin & Associates to collect payment for all authorized charges associated my treatment by processing a charge to the credit card listed above. I certify that I am the authorized signer of the credit card listed above.

Cardholder Name:
(Printed) _____

Cardholder Signature: _____ Date: _____