Rooting Through Grief, LLC

Bonnie Triantafillos-Wright, LCSW-C
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CREDIT CARD CONSENT

I _____ authorize Bonnie Triantafillos-Wright, LCSW-C to keep my credit card information on file and to use this information to charge and pay for psychotherapy sessions. I understand that I will be notified by invoice of the amount and nature of each charge.

Bonnie Triantafillos-Wright, LCSW-C will not use your credit card information for anything other than payment for the services listed above. Bonnie Triantafillos-Wright, LCSW-C will not release the Credit Card information to anyone aside from the service providers allowing for the transaction to be completed. Your information will be kept in a secure location.

Type of Credit Card: Visa Mastercard Discover American Express Debit/ Check Card
Credit Card Number_____
Expiration Date _____
Security Code (Last 3 Digits on back of card) _____
Pin Number (for check and debit cards only) _____
Email _____

Address _____
_____

Signature_____

Printed Name_____

Date _____

Clinicians Signature_____

Date _____