Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by Jennifer L Todd, LCSW. Initial _____

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Name [print]:____

Signature____

Relationship to client:____

Billing Address:____

Zip Code: _________________________________

Card Type (circle one): Visa MasterCard AMEX Discover

Acct. Number: ______________-________________-______________-____________

Exp. Date: ____________ 3 digit Security Code________________

I understand that my therapy sessions will be charged via this form and not by swiping my card on the morning of my session unless cancelled 24 hours in advance:

Cardholder Signature: ____

Date: __________