Debra Kaplan LLC

MA, LPC, LISAC, CMAT, CSAT-S
6151 E. Grant Road
Tucson, AZ 85712
520.203.1943

Authorization to Charge Credit Card

Date: ________________

I,______________________, authorize the use of this credit card, indicated below, to Debra Kaplan LLC for clinical services rendered. Payment made by credit card will be processed by Square, Inc., a credit card processing service and include a 3.5% fee.

I, ______________________, acknowledge payment will be charged $150/hr. and increments thereof, for missed sessions and session cancellation without a 24-hr. notification for a one hour session or 48-hr. notification for 2-hour sessions.

I, ______________________, acknowledge that payment for scheduled intensives are due upon receipt and are non-refundable. (If applicable)

☐ Visa
☐ MasterCard
☐ American Express
☐ Discover

Address of card holder: ______________________________

____

ZIP Code____________________

Name (as it appears on card) ___________________________

Card Number ______________________________________

Expiration Date ____________

Signature of Card Holder ______________________________