GrowWithTherapy
Dana Fogel-Stark, LMFT
23603 Park Sorrento Road
Calabasas, CA 91302

Permission To Use Credit Card To Bill For Services

Type of Credit Card: __ Visa __Mastercard

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: ____/____ _ Security Code/CVV: _____

By signing below, I give Dana Fogel-Stark, LMFT permission to bill my credit card for any or all services provided.

_____ _____
Signature of Cardholder Date