



RITA BRYCE, LISW
Child and Adult Psychotherapy
Shaker Hts, OH 44120
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CREDIT CARD AUTHORIZATION

I authorize Rita Bryce, LISW, to place my credit card information on file for the purposes of payment. I also authorize Rita Bryce, LISW, to charge automatically after each service is provided, including no-show appointments, as indicated in the signed treatment agreement.

Cardholder Information

Patient name

Cardholder name

Address

Visa Mastercard American Express

Card number

Security Code _____

Expiration Date _____

Cardholder's authorized signature

Date
