Kate Ferguson Therapy, LLC
4200 Northside Parkway,
Building 6
Atlanta, GA 30327
404-987-8876

Credit-Debit Card Payment Record

Client Name(s): ____

Card Number: ___________________________________ Expiration Date: __________

Credit Card Billing Information: ________________________ __________________

Street Number Zip Code

Security Code on the BACK of Credit Card (3 or 4 numeric digits): ______________________

Client Signature: ____

Signature indicates that you agree to allow your therapist to make charges on your card without you present.

Therapist's Name: ____

Card Used if Different from Above	Date of Session	Date Posted	Amount Posted	Authorization Code	Recorder's Initials