

**Psychotherapy Associates of Broward
Credit Card authorization**

I, _____ authorize Psychological Associates of Broward

to charge sessions for therapy on my _____ card

account number _____

expiration date _____ in the amount of _____.

I understand that sessions cancelled without 48 hours notice will also be billed for the above amount as agreed in the Policies and Procedures.

Signature: _____

Date: _____