Kathy Lucy, LMFT
809 Church Street
Decatur, GA 30030
(404) 376-3760

Credit/Debit Card Payment Consent Form *

I authorize **Kathy Lucy, LMFT** to charge my card for professional services as follows (please initial):

_____ All fees incurred from late cancellation/no show fees.

I understand that I have a right to revoke this authorization at any time. I understand that if I want to revoke this authorization, I must do so by writing or emailing Kathy Lucy (kathylucy@gmail.com). I understand that any revocation will not apply to any charges run prior to this cancellation date.

Client Name _____
Print Last First Middle Initial

Name on Card if different _____

Type of Card: ☐ VISA ☐ MasterCard ☐ Discover ☐ AmEx **Exp. Date** _____

Card Number _____ - _____ - _____ - _____ **CVV Number** _____

Card Holder's Billing Address for Monthly Card Statements:

_____
Street City State Zip

_____ _____
Email address (only if you want copies of receipts) Phone Number

Card Holder Signature _____ **Date** ____ /____ /____