

**Gina Watson, LICSW**

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**Credit Card Consent Form**

*\*This form is voluntary. If no credit card information is filed, you will be sent an invoice\**

Name: \_\_\_\_\_

Name on card: \_\_\_\_\_

Card type: \_\_\_\_\_

Card number: \_\_\_\_\_

Expiration date: \_\_\_\_\_

CCV: \_\_\_\_\_

I authorize Gina Watson, LICSW to charge my credit/debit/health account card for professional services. I understand that my information will be saved (in a HIPAA compliant format) for future transactions on my account.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied.

Client initials: \_\_\_\_\_

Cardholder initials: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_