Rajeive Manradgh, LAPC, LLC
2751 Buford HWY NE Atlanta, GA 30324

CREDIT CARD PAYMENT RECORD

Client Name as it Appears on Card: _____

Card Number: _____ Expiration Date: _____

Credit Card Billing Information: _____ _____ _____
Street Number Zip Code Security Code

Client Signature: _____
(Your signature indicates that you agree to allow your therapist to make charges on your card without you present and to store this information in an electronically encrypted HIPAA compliant manner.)

Therapist's Name: _____

Description of Service (e.g., 90847)	Date of Session	Date Posted	Amount Posted	Authorization Code	Recorder's Initials