Credit/Debit Card Information

If you would like your credit or debit card charged for any fees incurred by services provided by Cynthia Stanford, LMFT, please complete the following information:

Client Name: ____

Cardholder Name: ____

Visa/Mastercard (please circle) Number: ____

Expiration: ______________V-code: ________________ Billing zip code: ________________

I authorize my credit card to be billed by Cynthia Stanford, LMFT, for all copays, fees, and services rendered that are not covered by my insurance company

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Cardholder Signature

This form may be scanned and e-mailed to thea.stanford.counseling@hushmail.com or faxed to (802) 860-0183