Shannon Miles, M.A.

LMFT-4552

Licensed Marriage Family Therapist
www.shannonmilesmft.com

208-761-7677
smilesmft@gmail.com

ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information. Session fees for all clinical treatment will be deducted from the account designated on this form. Forms of payment accepted: Visa, MasterCard, Discover, and E-Checks. This form will be securely stored in your clinical file and may be updated upon request at any time.

***CLIENT INFORMATION*:**

Client Name: _____ **DOB:** _____

Responsible Billing Party Name (as shown on Credit Card/Account)**:**

_____

Billing Address (as registered with Credit Card Company/Bank)**:**

_____

Cell Number: _____ Home Phone Number:_____

Email: _____

***FORM OF PAYMENT*:**

Check One: ☐ Credit / Debit Card

***ACCOUNT INFORMATION*:**

Card Type (Visa, MasterCard, or Discover): _____

Card#: _____

Expiration Date: _____

_____

Client Signature Date

Please return this form to Shannon Miles, LMFT

LMFT-4552 208-761-7677 smilesmft@gmail.com