Ellyn L. Turer, PsyD, PLLC
1320 19th Street, NW
Suite 202
Washington, DC 20036
Tel: 202-293-6463
ellyn-turer@hushmail.com

Date______________________

AUTHORIZATION FOR CREDIT CARD PAYMENT:

Client name: ____

Card number: ____

Card expiration date: ___________________________

Card security code: _____________________________
(Mastercard & Visa: 3 digits on back of card; Amex: 4 digits on front of card)

Name as it appears on credit card: ____

Cardholder's name and address including zip code:

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I, ____, the cardholder, authorize Ellyn L Turer, PsyD, PLLC to process a charge to the credit card listed above for my monetary obligation solely related to my treatment with Dr. Turer. I understand that this card will be charged if I incur a missed appointment fee.

Cardholder's signature:

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