

Therapy with Joanna, P.C.
Joanna Frederick LCSW
484-477-8982
therapywithjoannafrederick@gmail.com

I _____ authorize Joanna Frederick, LCSW to keep my credit card information on file and to use this information to charge and pay for psychotherapy sessions and/or cancellation fees.

Joanna Frederick, LCSW will not use your credit card information for anything other than payment for the services listed above. Joanna Frederick, LCSW will not release the Credit Card information to anyone aside from the service providers allowing for the transaction to be completed. Your information will be kept in a secure location.

Credit Card Number _____
Expiration Date _____
Security Code (Last 3 Digits on back of card) _____
Address _____

Typed Signature _____
Date _____