STEPHANIE D. MILLER, MA
LMFT, LPC, LCDC

12401 S. Post Oak Rd. | Houston, TX 77045 | 281-552-8123

CREDIT / DEBIT CARD PAYMENT

DATE_____

PAYOR NAME _____

CLIENT NAME_____

ADDRESS_____

CITY _____ STATE _____ **ZIP CODE** _____

ACCOUNT#_____CVV_____

EXP DATE_____

This agreement provides **Stephanie D. Miller, MA, LMFT, LPC, LCDC** permission to charge my charge card as per my timeline, or in the event that I miss a scheduled appointment with less than 24 hours notice as explained in the Professional Service Agreement and Informed Consent, I authorize payment of fees stated via my credit/debit card (Visa, MasterCard, Discover, and American Express) .

Printed Name_____

Signature_____

Date_____