Ilana D. Rosenberg, Ph.D., Psychology, P.L.L.C.

I _____ authorize Ilana D. Rosenberg, Ph.D., Psychology P.L.L.C. to bill my credit card (information below) for all professional service fees not otherwise paid for at the time services are rendered. I understand that these fees include (but are not limited to) face-to-face consultation time, email and other written correspondence, telephone time, travel time to meetings, and other compensation for professional services. I also agree that my credit card can be billed for appointments that are not canceled with at least 48 hours notice and I further understand that any balance on my account at the time of termination of services will be charged to my credit card. Charges to my credit card should appear on my bill as "**Ilana Rosenberg**". I will notify my therapist if this is not the case. I also understand that I can withdraw this consent (in writing) at any time.

Card Type (circle one): Mastercard Visa

Card#:_____Expiration:_____/_____

CVV_____

Billing Zip code:_____

_____ _____

Authorizing Signature Date