**Credit Card Policy**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that as a condition of entering treatment with the psychotherapist Angela DeGiaimo, LCSW I must provide a valid credit card number and expiration date. Furthermore, I understand that my credit card will only be charged should I elect to do so as payment for sessions or for enforcing the cancellation policy of Angela DeGiaimo, LCSW.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Client (Print Name)**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Client Signature**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Date**