**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**