Credit Card Authorization

I authorize Andrew M. Leeds, Ph.D. to charge my credit card for all consultation services provided to me under the terms of the consultation agreement that I signed. This includes charges for missed appointments and cancellations with less than 2 business days notice.

Cardholder's Name as it Appears on the Card:

_____

Cardholder's Billing Address with Zip Code:

Street: _____

City: _____

State: _____ Zip Code: _____ Country: _____

Phone: _____

Card Type:

❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

Card Number:

_____

Expiration Date: _____/_____ CVS # _____

(3 or 4-digit security number on your card)

Cardholder's Signature:

_____

Name: _____

Today's Date: _____

Mail or Fax to:
Andrew M. Leeds, Ph.D., 1049 Fourth St., Suite G, Santa Rosa, CA 95404
Phone: (707) 579-9457, Fax: (707) 703-5334