

Client: _____

Leslie A. Campbell, LCSW
Five Tribes Therapy
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AUTHORIZATION FOR PAYMENT

I authorize Leslie A. Campbell, LCSW, to charge my credit card for fees including:

- Fees for services rendered
- Missed appointments that are not cancelled within at least 24 hours advance notice

This authorization is ongoing and will be automatically revoked six months after the last date of service. Until that time, I authorize payments as described above.

I understand this six month time period may be required to determine final amounts due and settle my account; and that my credit card may be billed during this time, and expiration or cancellation of a credit card does not relieve me of unpaid debt.

Credit Card Number: _____

Expiration Date: _____

V Code (*on back of card*): _____

Billing Address: _____

Billing Zip Code: _____

Signature: _____

Date: _____