



The office of

ILONA STRASSER, M.A., LMFT

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Credit Card Payment Authorization Form

Sign and complete this form to authorize **Ilona Strasser, LMFT** to make a debit to your credit card listed below upon time of service, at the end of each therapy session.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date, and for each session of therapy thereafter. This is permission for therapy sessions with Ilona Strasser only, not unrelated debits or credits to your account.

Please complete the information below:

I _____ authorize **Ilona Strasser LMFT** to charge my credit card
(full name)

account indicated below for \$250.00 per therapy session on or after January 1, 2025. This payment is
(amount) (date)

for each 50 minute therapy session. The amount of the charge is indicative of the number of sessions being charged.
(description of goods/services)

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

Account Type:	Visa	MasterCard	AMEX	Discover
Cardholder Name	_____			
Account Number	_____			
Expiration Date	_____			
CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX)	_____			

SIGNATURE _____

DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for

the duration of time in therapy. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.