

**PTSD SOLUTIONS THERAPY
THE HELPING PLACE, LLC**
3001 W. Hallandale Beach Blvd.
Suite 302
Pembroke Park, Florida 33009
M. 954-455-0388 F. 954-455-7588
e-mail: ptsdsolutionstherapy@gmail.com
web: www.Ptsdsolutionstherapy.com

Patient's (Client) Name: _____

Please circle type of Credit Card: Visa MC AmEx Discover

Use this form to pay for services rendered. This signed form gives The Helping Place, LLC permission to bill using the information contained. Simply complete the information requested, then sign where indicated.

Once done, you approve all billings, which coincide with visits to the Helping Place, LLC. .

Name on Card: _____

Credit Card No: _____

Exp Date: ____ ____

3 or 4 Digit CVS Code: ____ ____

BILLING ADDRESS OF CREDIT CARD _____

_____ **STATE** _____ **ZIP CODE:** _____

Home Phone Number: _____ Cell Phone: _____

Email Address: _____ @ _____ . _____

Total Charges for Services: \$ _____

Cardholder Signature: _____

Printed Name: _____ Date: ____ ____ 201 ____

This may be revoked by sending a signed and dated Letter of Revocation to the above listed address.
The letters' postmark shall determine the revocation date.