

Celia Hartnett, MSW, LCSW
Credit Card Information Form

Patient's Name: _____

Responsible Party: _____

VISA MASTERCARD HSA OTHER

Credit card number: _____

CVA: _____ Expiration date: _____/_____

Address associated with card: _____

Signature: _____

My signature authorizes Celia Marie Hartnett, LCSW, to use this credit card for payment of psychotherapy services. I understand that I will be charged at Ms. Hartnett's usual rate for any appointment I miss or any appointment I cancel with less than 24 hours notice.