



HEMISPHERES
COUNSELING CENTER

I, _____ authorize (Jamie Simkins, LCPC)
to make charges to the following credit card for payment of mental health
counseling services.

CREDIT CARD NUMBER _____

EXPIRATION DATE _____

3 DIGIT CODE _____

NAME ON THE CARD _____

ZIP CODE of BILLING ADDRESS _____

This agreement will remain in effect until this agreement is cancelled in writing by the
undersigned.

Signature

Date