

Restoration Counseling
Alyssa Meyers, M.A., LPC #72648

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(936)-203-1772

CREDIT CARD PAYMENT INFORMATION

Please complete if you would like payment deducted by one of these means:

☐ Visa/Debit

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Name on Card: _____

Account Number: _____

Billing Address: _____

Expiration Date: _____ Security Code: _____

Authorized Signature: _____

*By signing, you understand that any cancelation and no-show fees will be charged to the card listed above.

Would you like a copy of the receipt emailed to you after each deduction?

☐ Yes, email address: _____

☐ No

Would you like a hard copy receipt after each counseling session?

☐ Yes

☐ No

The information provided will remain confidential and will be utilized for rendering reimbursement of provider services.