<u>Heart Journey Christian Counseling, LLC</u> 500 W. Lanier Ave, Suite 908, Fayetteville, GA 30214 * 678-300-8296 * www.heartjourneychristiancounseling.com

CREDIT CARD PAYMENT RECORD

Client Name:				
Name as it appears on the	credit card (if differen	nt):		
Card Number:		xpiration Date:	Security C	ode:
Credit Card Billing Address	SS:			
Street			City, State	Zip Code
Authorized Signature:				
(Signature indicates that you agree to	to allow your therapist to ma	ike charges on your card wit	hout you present.)	
Therapist's Name: Malika	King, LPC			
Description of Service	Session Date	Type of Pa	vment A	mount of Payment
		J F		-
				