

Jennifer Brown, LLC
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This is to certify that I give permission for bills/invoices/monthly statements to be sent to me via email at the following address:

Email: _____

Name

Date

This is to certify that I give permission for my credit card/ debit card/ health card to be charged/ run as needed by Jennifer Brown, LCSW for payment of therapy sessions and/or canceled or missed sessions for myself or child. This is in effect until otherwise stated in writing. The credit card being used is:

#

Expiration

CVV

Zip Code

Signature

Date