TRILLIUM SPRINGS COUNSELING
1640 Powers Ferry Road, Building 16, Suite 300, Atlanta, Georgia 30067

Credit-Debit Card Payment Record

Client Name(s): ____

Card Number: ______________________________Expiration Date: ____________

Credit Card Billing Information: ______________________ ______________
Street Number Zip Code

Security Code of the BACK of Credit Card (3 or 4 numeric digits): ______________

Therapist's Name: ____

Card Used if Different from Above	Date of Session	Date Posted	Amount Posted	Authorization Code	Recorder's Initials