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Credit Card Authorization Form

I, _____ hereby authorize Dr. Gelareh Solomon to charge my credit card account in the amount due.

VISA Mastercard American Express

Credit Card Number: _____

Expiration Date: ____/____ VID Code: _____

Credit Card Billing Address

Street: _____

City: _____ State: _____

Zip Code: _____ - _____ Country: (if not USA) _____

Telephone: _____ - _____

Signature _____

As the credit card holder, I authorize Dr. Gelareh Solomon to charge my credit card for the amount due.

Your completion of this authorization form helps us to protect you from credit card fraud. Dr. Solomon will keep all information entered on this form strictly confidential.