

**Clinical Expertise in Treatment of:**

Family/Marital Issues  
Disruptive Disorders of Children  
Anxiety and Depressive Disorders  
Anger Management  
PTSD  
Crisis Intervention  
Grief and Loss

**Clinical Therapy**

Florida LCSW #10560  
LCSW Qualified Supervisor  
State Certified Expert Witness  
Adoption-Competent Certified

## Credit Card Authorization Form

Please complete all fields and email AchesonTherapy@gmail.com or text back 813-727-0264 with a photo of this. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____/_____
Cardholder ZIP Code (from credit card billing address): _____

I, \_\_\_\_\_, authorize Kimberly Acheson to charge my credit card for any copay, member responsibility, or deductible required from my insurance provider. I understand that my information will be saved to file for future transactions on my account.

\_\_\_\_\_  
Customer Signature

\_\_\_\_\_  
Date