

Carol R. Hirshfield, Ph.d.

A Psychological Corporation
Clinical Psychologist (PSY 16827)

11340 W. Olympic Blvd., Ste. 265
Los Angeles, CA 90064
Office Telephone (310) 473-3200
Fax (310) 479-4718

Authorization to Use Master Card or Visa for Payment

For: _____ Co-Parent Name: _____
Your name

Day of class: (circle) Thursday/Saturday Date class begins: _____

I hereby authorize Dr. Carol Hirshfield to charge the \$360 fee (per person) for enrollment in the course *Co-Parenting with my Ex*®, to my credit card, as follows. This signature also signifies my understanding that I am NOT entitled to any refund if I withdraw after the series has started, even after one class:

____ Master Card ____ Visa Total Fee: \$ _____

Card No. _____

Expiration Date _____ CVV Code (3 #s on back) _____

Name as it appears on my card: _____

Billing Address: _____

Address

City

State

Zip code

Phone Number: _____ email: _____

Signed: _____ Date: _____

[Receipt will be mailed or emailed upon completion of the transaction, if time permits.
Or, a receipt will be hand delivered at the first class.]