CREDIT CARD AUTHORIZATION FORM

Client Name: _____
Phone: _____ **Email:** _____

Cardholder Name: _____
Card Type: Visa / Mastercard / Amex / Discover
Card Number: _____
Expiration Date: _____ **CVV:** _____
Billing ZIP Code: _____

Authorization

I authorize the practice to keep my credit card on file and to charge my credit, debit, HSA, or FSA card for professional services rendered.

I have read and understand the 48-hour cancellation policy detailed in the PSYCHOTHERAPIST-PATIENT CONTRACT. If I fail to cancel at least 48 hours in advance or do not attend a scheduled appointment, I authorize my card to be charged the full session fee of $135.

I verify that the payment information provided is accurate to the best of my knowledge. If this information is incorrect, fraudulent, or payment is declined, I understand that I am responsible for the full balance due.

Description of Services:

_____

Cardholder Initials: _____

Cardholder Signature: _____
Printed Name: _____
Date: _____