1247 Milwaukee Ave. Suite# 208 Glenview, IL. 60025~224.257.4190

Credit Card Authorization

Credit card information is to remain on file for charges accrued by late cancellation or missed sessions, and services rendered during scheduled sessions in the office. This form will be kept securely and can be updated at any time upon your request.

I, ____understand the payment policies and authorize Rooted Mind Counseling Center, LLC to charge my credit card in the event:

- I do not attend a scheduled therapy appointment that I have not cancelled 24 hours in advance ($100 fee)
- My check is returned for any reason

Card Type: ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's name (if different from above): ____

Card #: ____ Exp. Date: ____________________________

Name as printed on card: ____

Verification/Security Code (on back):_____________________ Billing Zip Code: _________________

Client Signature:____ Date: ______________________

Recurring Payment Option

By signing below, I accept and acknowledge that my information be securely stored for regular payment and authorize Rooted Mind Counseling Center, LLC. to charge my credit card on an ongoing basis for scheduled appointments.

Client Signature:____Date:____________________