KID POWER COUNSELING

Empowering families one child at a time

CREDIT CARD AUTHORIZATION FORM

Name on credit card*:* _____

Billing Address (please include zip code):

_____

Primary Phone Number: _____

Credit Card Number:_____

Expiration Date: _____

CV Number on the back of the card: _____

E-Mail Address to forward receipt:_____

I authorize **KID POWER COUNSELING**, **Karen Orth**, to charge my credit card for services provided. I understand that 24 hours' notice is required if I am not able to keep my appointment. I understand that I am responsible to pay for cancellations with less than 24 hours' notice. I also authorize to charge any fees accrued in using the SQUARE App to collect these monies.

Upon request, I will receive a copy of the receipt of the fees being charged. I understand that KID POWER COUNSELING will keep my credit card information on file, but that the utmost caution will be taken in insuring the confidentiality of this information. I understand that I have financial responsibility for this account. I understand that this account is a self-pay and I am aware that I am responsible for all treatment costs. I further understand that I must pay for each session at the time that services are received. This agreement will remain in effect and my card will be charged until services are completed or this authorization is revoked in writing.

List All Clients Authorized to Receive Services Paid for by this Credit Card:

_____ _____

_____ _____

Licensed Clinician, KAREN ORTH, LMFT, RPT-S

_____ _____

Authorized Credit Card Holder Signature Date

KID POWER COUNSELING

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