****

**Alice Carpenter Bentley, BC-LPC, CPCS**

Psychotherapist

5755 North Point Parkway, Suite 238

Alpharetta, GA 30022

(404) 689-1937

**CREDIT CARD AUTHORIZATION FORM**

**24 Hour Cancellation Policy:** If you do not provide notice at least 24 hours prior to the cancellation of your scheduled appointment, you will be charged the full rate of the appointment. (Unless otherwise specified, you will receive an automated reminder of your appointment 48 hrs. earlier.) If you are using insurance, they do not reimburse for missed appointments, however, I will only charge the contracted insurance amount. Signing this agreement authorizes our office to charge the card listed below for missed appointments. I understand it is my responsibility to provide the new information when my card expires.

**Please complete the information below:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Alice Carpenter Bentley, LLC to charge my credit card indicated below for payment of services or for fees as discussed.

Your credit card may be charged after each appointment for the amount of services rendered unless other arrangements are made. Authorization can be cancelled at any time with written consent.

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I authorize the above named business to charge the credit card indicated in the authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization.**

Account Type: VISA \_\_\_\_ MasterCard \_\_\_\_\_ American Express\_\_\_\_\_ Discover \_\_\_\_\_

Cardholder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This payment authorization is for the type of bill indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.**