CREDIT CARD AUTHORIZATION FORM

Insight Professional Counseling, LLC

Celeste Daiber M.Ed., LPC-S, NCC, RPT

CREDIT CARDHOLDER INFORMATION

Name on Credit Card:_____

Type of Credit Card: **visa** **m/c** **amex** **discover**

Type of Account: **Personal** **Business**

Company Name:_____

Account Number:_____**CVC#:**_____

Expiration Date:_____

Billing Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone:_____**Email:**_____

AUTHORIZED USER OF CREDIT CARD:
Insight Professional Counseling LLC
Celeste Daiber M.Ed., LPC-S, NCC, RPT
636-724-1224 Fax: [866] 361 8832
celeste@kscounselingstl.com

I HEARBY AUTHORIZE THE FOLLOWING CHARGES TO BE APPLIED TO THE CREDIT CARD.

_____Weekly co-pays **_____$25 Day of cancellation fee**

_____$50 No-show fee **_____$25 Report writing fee**

Signature of Card Holder:_____**Date:**_____

Signature of Therapist:_____ **Date:**_____