

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@celestedaiber.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:** _____