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Credit Card Authorization Form

Until All The Pieces Fit Payment Authorization for Mental Health Services

Thank you for choosing Until All The Pieces Fit for your mental health care. Please complete this form to authorize charges to your credit/debit card for services rendered, late cancellations, or missed appointments.

Client Information

Client Name: _____

Date of Birth: _____

Phone Number: _____

Email: _____

Cardholder Information

Name on Card: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Card Details

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

Card Number: _____

Expiration Date (MM/YY): _____

CVV: _____

**Authorization

I authorize Until All The Pieces Fit to charge my card for the following:**

- **Therapy sessions** at the agreed-upon session fee.
- **No-show/late cancellation fees** in accordance with the cancellation policy (At least 24 hours' notice prior to scheduled appointment).
- **Outstanding balances** associated with services rendered.

I understand that: - This authorization will remain in effect until I provide written notice to revoke it. - I am responsible for ensuring my card information is up to date. - Charges may appear under the business name "Until All The Pieces Fit."

Signature

Cardholder Signature: _____

Printed Name: _____

Date: _____

Thank you for your cooperation.