



CREDIT CARD AUTHORIZATION FORM

Client Information

Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email: _____

Cardholder Information (if different from client)

Name on Card: _____

Relationship to Client: _____

Billing Address: _____

Phone Number: _____

Payment Authorization

I, the undersigned, authorize Sandbar Psychological Services to charge my credit/debit card listed below for services rendered, including but not limited to psychotherapy sessions, assessments, late cancellation fees, missed appointment fees, and other agreed-upon services.

This authorization remains in effect until I provide written notice of cancellation.

Card Information

Card Type: Visa Mastercard American Express Discover

Other: _____

Card Number: _____

Expiration Date: _____ CVV: _____

Billing Zip Code: _____

Authorization Agreement

I understand that:

- I am responsible for all charges incurred for services provided.
- Charges may be processed on the date of service or according to the practice's billing policy.
- This authorization will remain valid for ongoing treatment unless revoked in writing.
- Revocation of authorization does not affect charges already processed.

Signature

Cardholder Signature: _____

Printed Name: _____

Date: _____

Optional Add-On (HIPAA/Practice Policy Acknowledgment)

I acknowledge that payment information will be stored securely and handled in accordance with applicable privacy and security regulations.