



Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time, in writing, in accordance with the Cancellation Policy stated below.

Credit Card Information

Card Type: Visa Mastercard American Express

Cardholder Name:

(as shown on card)

Card Number:

Expiration Date:

(MM / YY)

_____ / _____

CVV:

(3 Digits)

Cardholder

Postal Code:

I, _____, authorize the Door of Hope Counselling Clinic, Inc. to charge my credit card the amount of \$_____ for _____ number of sessions for a total of \$_____.

(Customer Signature)

(Date)

Cancellation / Refund Policy

A cancellation for any of the Door of Hope Counselling Clinic promotional packages must be made in written form via email. There are three (3) refunds available: (1) if the cancellation is received **WITHIN** five (5) business days after the payment has been made, there will be a 100% refund; (2) if the cancellation is received **WITHIN** ten (10) business days after the payment has been made, there will be a 50% refund; (3) if the cancellation is received **AFTER** ten (10) business days after the payment has been made, there will be **NO** refund. The remaining unused amount can be transferred to another person who could utilize these remaining counselling sessions. This unused amount must be used **WITHIN** six (6) months of the transferred date.