Credit Card Authorization Form

I (name of card owner) authorize Center For Integrated Care to charge my credit card $\_\_\_\_\_\_\_ (for my copay or therapy session), as well as $\_\_\_\_\_\_\_ for cancellation of sessions not honoring the 24-hour cancellation policy and missed sessions to the following credit or debit card:

Authorized signature of cardholder Date

Printed name of cardholder

☐ Amex ☐ Visa ☐ Mastercard ☐ Discover

Credit Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ CVV Code

Name as it appears on card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip \_\_\_\_\_ \_\_\_\_\_\_

E-Mail (if you prefer to receive your receipts there) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By failing to cancel a scheduled appointment within at least 24-hours of your session time, I am

unable to offer the time-slot to another client, and you will be billed $\_\_\_\_\_ for your missed session.

Thank you for your understanding and cooperation regarding this important matter.