Healing Concepts, LLC
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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Client's Name: _____

Cardholder Name: _____

Name as it appears on the Card: _____

Type of Card: Visa ___ MC ___ AmEx ___ Discover ___ Other ___

Account number: _____

Expiration Date: _____

CCV Number (last 3 digits located on the back of the credit card): _____

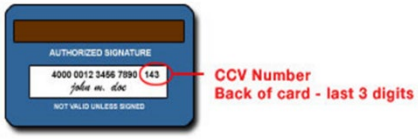
Billing Address: _____

City, State, Zip: _____

Phone Number: _____

American Express

Visa, MC, Diners Club, Carte Blanche, Discover



By signing this form, I authorize Healing Concepts, LLC/Paul C. Briggs, LCSW, LMT, SEP to charge my credit card above for agreed upon fees. I understand that my card will only be charged one time per session attended. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Card Holder's Signature Date

_____

Printed Name