ELECTRONIC PAYMENT AUTHORIZATION

I authorize the use of the card designated below for all my provider's services and fees for varying session types, across multiple dates of service, through this practice at the time services are rendered or following, for the following parties.

I understand by signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service until I revoke this in writing.

I authorize all charges to be deducted from the card ending in _____ (last four digits of the card).

Please enter the CVV code _____ (last three digits on back of card).

Cardholder's Billing Information:

Name:_____

Address:_____ City:_____ State:_____

Zip:_____ Mobile Number(s):_____

Email:_____

I prefer receipts sent to the above contact information by: ☐ Text ☐ Email ☐ None

If different than cardholder:

Client Name:_____

Client Name:_____

Client Name:_____

_____ _____

Cardholder Signature **Date**

Late cancel/ no show policy:
If appointment is canceled at least one hour, but less than 24 hours, you will be charged $25 for the scheduled session (LATE CANCEL FEE). Cancellations of less than an hour will be considered a "NO SHOW" and you will be charged a full session fee, unless an emergency occurred determined by therapist.

I revoke this effective:

_____ _____

Cardholder Signature **Date**

Debit/Credit Card Information: (The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.)
Payment information:

Card (circle one): Visa MasterCard Discover American Express

Card Number:_____ Expiration Date: _____