Authorization for Credit Card Use

l,			authorize			
to c	charge my credit/debit ca	ared for the following	9:			
	☐ Individual, couples or family counseling/consultation sessions ☐ For any appointments missed or canceled with less than 24 hours notice					
	Copay or coinsurance rate for all attended appointments					
	□ Any portion of billable services not covered by client's insurance policy□ Other					
Ш	Other					
	Credit Card Information					
	Card Type: Ma	ster Card	Visa	Discover	Amex	
	Cardholder Name (as s	hown on card):				
Card Number: Securit				Security Code:		
	Expiration Date: (mm/yy) Cardholder Zip Code: (from credit card billing address)					
	Email for receipt to be sent:					
l,	, understand that payment is due at the time of					
	service, including treatment expenses not covered by insurance, missed appointments, and copayments. I					
	l have the option of payir		,	• • • • • • • • • • • • • • • • • • • •	. •	
bal	ance or a missed appoint	ment, I authorize			to use	
this	s credit card information	as payment for serv	ices.			
Cli	Client Signature		Date			