



## CREDIT CARD AUTHORIZATION FORM

Please complete this form and return to your therapist. All information will remain confidential.

Client Name: \_\_\_\_\_

Therapist Name: \_\_\_\_\_

CREDIT CARD INFORMATION			
Card Type:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA	<input type="checkbox"/> Discover <input type="checkbox"/> AMEX
Cardholder Name (as shown on card): _____			
Card Number: _____			
Expiration Date (mm/yy): _____			
Card Identification Number (3 or 4 digits located on the front/back of the card): _____			
Cardholder ZIP Code (from credit card billing address): _____			
Amount to charge per session: \$ _____ (USD)			
Would you like a receipt emailed/texted to you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please indicate an email or phone number: _____			

I authorize \_\_\_\_\_ to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement. I understand that my information will be kept on file for future transactions on my account.

\_\_\_\_\_  
Cardholder Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name