Credit Card Authorization Form

A credit card will be kept on file for all clients. By signing this form, I understand that I may choose to use other forms of payment, such as cash, check, or an HSA account, and pay at the time of service. However, I understand that if my account balance is 30 days overdue, I authorize my therapist to automatically charge this card.

Name on Card: _____

Card Number: _____ CVV Code: _____ Expiration Date: _____

Type of Card: *Visa* *American Express* *Mastercard* *Discover* Billing Zip Code: _____

Client Signature _____

Date _____