Credit Card Authorization Form

I, ____, hereby authorize Metropolitan Counseling Services to use the following credit card information payment on behalf of ____.

I am aware that payment is due at the time of service. I understand that I am responsible for payment of all sessions I attend, as well as for those appointments that I fail to cancel without giving notice of at least 24 hours.

Agree to one and initial one of the following:

My therapist, ________________________, may charge this card for appointments held, cancellations less than 24 hours before appointment and no shows. ____

My therapist, ________________________, may only charge this card in the event of a cancellation less than 24 hours before appointment or no shows. Another form of payment will be used for appointments held. ____

Credit Card Number: ____

Type: VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Expiration date: ___________________________ CVV ___________________

Name as it appears on card: ____

Credit Card statement address: ____

__________________________ZIP CODE:____________

PHONE: _________________________

EMAIL: __________________________

Cardholder signature Date

Please note this information will be held in your confidential clinical file. This paper will be destroyed at the end of your care with MCS.