Alvord | Baker & Associates, LLC

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Permission To Use Credit Card

Whenever check/cash payment is not provided at the time of service, please **charge fees associated with the following patients.** *This includes charges for missed sessions not cancelled within 24 hours.

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_____

_____

I also understand that group therapy sessions are charged by the month at the beginning of each month. (Example: If a month has 4 sessions, I will be charged for all 4 sessions at the beginning of the month.)

Name on Card: _____

VISA/Master/Discover Card (AMEX not accepted)
Enter entire credit card number:

_____

Billing Address on Card:

_____ _____
Street

_____ _____ _____
City State Zip

Expiration Date of Card: _____

CVC Code on back of card: _____

Cardholder Signature: _____

Date: _____