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Permission To Use Credit Card

Whenever I am not present to pay in person at the time of service, please **charge fees associated with the following patients**. This includes charges for telehealth sessions as well as missed sessions not cancelled within 24 hours of the appointment time.

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: _____