Joyful Hearts Counseling

CREDIT CARD AUTHORIZATION

Client Name: _____

Parent/Guardian name:_____

Please initial below for each item:

( ) I hereby authorize Joyful Hearts Counseling to bill the below-referenced credit card for routine treatment services for myself and/or my minor child.

( ) I understand that I can rescind this authorization at any time and arrange for alternative fee payment methods (i.e. cash, check, or alternate credit card).

( ) I acknowledge that in the event of missed or late canceled appointments (canceled with fewer than 48 hours' notice), my card will be charged a full session fee ($120.00 per session) for the missed appointment.

( ) I have been made aware that a record of all fees associated with my or my child's treatment can be made available to me within seven (7) business days of my request.

Card Holder Name: _____

Credit Card Number: _____

Expiration date: _____CVV:_____

Billing Address: _____

_____

Card Holder Signature: _____ DATE: _____

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