CREDIT CARD AUTHORIZATION FORM

All information provided on this form will be kept confidential. Please read all sections carefully. If you have any questions, please contact your Family Guiding therapist before signing.

Payment Frequency:

- ☐ **One Time Payment**: Bill my credit card once for the following amount $ _____
- ☐ **Repeat Payment**: automatically charge my credit card ***per session*** for the service provided
- ☐ **Other:** _____

Credit Card Information:

Credit Card Type: ☐ Visa ☐ Mastercard ☐ Discover

Name (as it appears on card): _____

Credit Card Number: _____

Expiration Date: _____ /_____ **CVC Number (on back of card):** _____

Billing Address: _____

City/State/Zip: _____

Email Address: _____

I authorize Family Guiding Psychological Services, PLLC to charge the above referenced credit card account and apply said charges toward the payment of services rendered. I certify that the above information is accurate and acknowledge that Family Guiding may seek alternative form of payment if charges are declined or charge backs are claimed against any outstanding invoice. I understand that it is my obligation to notify Family Guiding of any changes in the status of this card.

_____

(Printed Name)

_____ _____

(Signature of Authorized Individual) (Date)