CREDIT CARD AUTHORIZATION FORM

INTEGRITY COUNSELING CENTER

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I, _____, authorize Kelsey Hawk, LMHC, to charge my credit card for professional services as follows:

Please Initial:

_____ Recurring charges for services in the amount of $_____ per visit.

_____ I understand and agree that my card will be charged a fee of $100.00 for cancellations with less than 24 hours notice and for appointments I miss without notice as agreed to in the Client Consent and Disclosure Form I signed.

_____ I understand and agree that my card will be charged for balances of charges not paid by me or my insurance (such as deductibles and copays).

_____ I understand this form is valid for one year unless I cancel the authorization in writing. I will not dispute charges ("charge back") for sessions I have received or appointments I missed according to the above policy.

Charges will appear on your credit card statement as "Kelsey Hawk."

☐ Visa ☐ MasterCard ☐ Debit Card

Card #: _____

Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (the 3---digit code on back of card by signature line): _____

Billing Address (Street, City, State & Zip): _____

_____

Email Address:

Signature		Printed Name		Date	