

# CREDIT CARD AUTHORIZATION FORM

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 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