



Credit Card Authorization Form

Please Complete this authorization form and return to us. All information will remain confidential.

I _____, hereby authorize Counseling with Care to
(Credit Card Holder)

automatically charge my credit card to pay outstanding fees due to unmet deductibles. I also authorize the card to be used to cover the cost for any fees occurred for missed sessions or sessions canceled with less than the 24 hour notice required. I understand these transactions will occur without additional notice. I understand that fee payment deadlines, and/or late fees are my responsibility. I further understand that I may be charged a penalty fee if the credit card company denies my credit card.

<input type="radio"/> Visa	<input type="radio"/> Mastercard	<input type="radio"/> AmEx	<input type="radio"/> Discover
Cardholder Name (as it appears on the card) _____			
Cardholder Billing Address: _____			
City: _____ State: _____ Zip Code: _____			
Credit Card #: _____			
Expiration Date (MM/YY): _____ / _____ CVV Security Code _____			

I, the undersigned agree to all the conditions set forth in this credit card authorization.

Signature of Cardholder: _____ Date: _____