



CREDIT CARD AUTHORIZATION FORM

Date: _____

Client Name: _____

Client Date of Birth: _____

Guarantor Name (if different): _____

Guarantor Date of Birth: _____

Full Billing Address: _____

City, State, Zip Code: _____

Phone Number: _____

Check one of the following options:

Enter my credit card into a secure credit card payment gateway for future use.

- I hereby authorize Elena G. Kaiser LCPC ATR BC to allow TherapyPartner.com a secure, data compliant intermediary credit card payment gateway to keep my account information on file for payment and to initiate debit or charge entries.
- I acknowledge that debit or credit card transactions to my account must comply with U.S. law and that a debit or charge may be made to my bank account or credit card account periodically to pay for amounts owed for services provided at Elena Kaiser Psychotherapy LCPC ATR BC.
- If my bank account or credit card information listed above changes for any reason, I will notify Elena Kaiser Psychotherapy LCPC ATR BC and provide a new form.
- This authorization shall remain in effect until Elena Kaiser Psychotherapy LCPC ATR BC has received a written notification from me of its termination or until services end and are paid.
- I understand that my credit card will be charged the full fee in the event of a cancellation or a no show.
- In the event that my card is charged and a refund is requested in order to substitute a different card, a \$25 fee will be assessed per transaction.

Onetime Charge (CVV Required below)

Charge my credit card for this one time only for \$ _____

Date of Service: _____

Replace old card on file (Please rewrite new card number below)

Signature of Cardholder: _____

Therapist: _____

Office Use only: Billing initials

Date:

The bottom of this form will be destroyed after use:

Visa MasterCard Discover

Card Number: _____ CVV: _____

Expiration Date: _____