

**AUTHORIZATION FOR CREDIT CARD CHARGES**

For your convenience, you may authorize recurring charges to your credit card to pay for your therapy sessions. You will be charged the day of your therapy appointment unless other arrangements have been made. The charge will be made under the name Professional Psychological Services. You agree that no prior notification is necessary to charge your card after each session.

Name of Client: \_\_\_\_\_

Account Type:     Visa     MasterCard     American Express     Discover

Cardholder Name: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

CVV (3-digit number on back of Visa/MC or 4-digits on front of AmEx): \_\_\_\_\_

Billing Address:  
\_\_\_\_\_  
\_\_\_\_\_

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify this practice in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date.

Signature of Authorized Credit Card User: \_\_\_\_\_

Date: \_\_\_\_\_