Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover

☐ American Express ☐ Other ______________________________

Cardholder Name (as shown on card): ____

Card Number: ____

Expiration Date: (mm/yy): ________ /________

Card Security Code (3 digits): _________

Cardholder Zip Code (from credit card billing address): ____________________

Client name(s) this authorization applies to: ____

Payment Terms:

☐ weekly payments of $________________

☐ bi-weekly payments of $_____________

☐ monthly payments of $______________

☐ co-pay or co-insurance after each session

☐ co-pay or co-insurance monthly

I, _______________________________________, authorize Alliance Counseling (Jean Allbee-Roberson LMFT LLC) to charge my credit card above for agreed upon charges. I understand that my information will be saved on file for future transactions on my account. My card will only be charged as described above or if my account is 90 days past due. I also understand that the these charges may include co-pays, co-insurance, amounts applied to my insurance deductible, charges not paid by my insurance company , missed appointment fees, and interest on balances more than 60 days overdue. This payment authorization is to remain in effect until I notify Alliance Counseling (Jean Allbee-Roberson LMFT LLC) of its cancellation by giving written notice in enough time for the business and receiving financial institution to have a reasonable opportunity to act on it.

____ ____________________

Cardholder signature Date