Credit Card Authorization

Grace Counseling
7921 Southpark Plaza, Suite 204
Littleton, CO 80120
(720) 489-8555
FAX: 720-489-8304

I hereby authorize **Grace Counseling** to keep my credit card number on file along with information needed to process a sale, and charge my card each time the following patient receives therapy from Grace Counseling.

PLEASE PRINT CLEARLY

_____ _____ - _____ - _____ _____
NAME ON CARD (CARDHOLDER) CREDIT CARD NUMBER

_____ EXP:____/____ 3 or 4-DIGIT SECURITY CODE _____
BILLING ADDRESS FOR CARD

_____ **MC Visa Discover American Express**
CITY, STATE, ZIP (CIRCLE ONE)

_____ _____ _____ _____
PATIENT NAME RELATIONSHIP TO CARDHOLDER (SELF, CHILD, SPOUSE, FRIEND) THERAPIST FEE

- I understand that the above card will be **automatically charged for a missed appointment, or an appointment not canceled 48 hours in advance** per Grace Counseling policy.
- I understand that I may revoke this authorization at any time by written notification to the front desk staff at Grace Counseling. This authorization will be in effect until the card's expiration date (listed above) or until revoked by the cardholder, whichever comes first.
- I certify that I am the authorized signer for this card.

Signed,

_____ _____
CARDHOLDER SIGNATURE DATE

_____
PHONE NUMBER
where you can be easily reached

This form to be kept in patient's file.