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: _____

Terms of payments (to be completed by office): _____

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 not be charged unless I give written (including e-mail) or verbal permission, or if my account is 60 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.

_____ _____

Cardholder or authorized representative signature Date