Credit/Debit Card Authorization

Sign and complete this form to authorize FOOTHILLS COUNSELING & WELLNESS LLC to charge/debit your card listed below.

By signing this form, you give us permission to debit your account.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize FOOTHILLS COUNSELING & WELLNESS

LLC to charge my credit/debit card indicated below on or after the date of \_\_\_\_\_\_\_\_\_\_\_ for the professional services and fees as follows:

*Initial both statements below to indicate agreement.*

\_\_\_\_\_\_\_ To charge my card for any balance owed, including fees not paid at the time of service or not covered by my insurance company.

\_\_\_\_\_\_\_To charge my card for any Missed Appointment or Late Cancellation fees which I may incur.

*Complete Address info only if card billing address is different from what we have on file as your home address:*

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

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
|  Account Type: [ ]  Visa [ ]  MasterCard [ ]  Discover Cardholder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_16 Digit Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE DATE \_\_\_\_\_\_\_\_\_  |

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for up to the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.