



## Credit Card Authorization Form

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I authorize Family Perspectives, LLC, to charge my credit/debit/HSA card for professional services as follows:

Please Initial each of the following except the first sentence unless applies:

\_\_\_\_\_ Recurring charges for services in the amount of \$\_\_\_\_\_ per visit.

\_\_\_\_\_ \$55 for cancellations with less than 24 hours notice and for appointments I miss without notice.

\_\_\_\_\_ Individual appointments I choose to pay by credit card.

\_\_\_\_\_ I understand that my card will be charged for returned checks for the amount of the check plus \$35 per check.

\_\_\_\_\_ Balances of charges not paid including fees incurred in phone or internet treatment without payment rendered for 7 days.

\_\_\_\_\_ I will not dispute charges for sessions I have received, appointments I have missed, or charges due to bounced checks.

I, \_\_\_\_\_, am authorizing Family Perspectives, LLC to bill my credit card in the even of any appropriate scenario initialed above.

Charges will appear on your credit card statement as [familyperspectives@gmail.com](mailto:familyperspectives@gmail.com) 480-277-0049

Card Type (circle one):    Visa    MasterCard    Discover    American Express

Card #: \_\_\_\_\_

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

Name as Printed on Card: \_\_\_\_\_

Verification/Security Code (3-digit code on back by signature line-MC/Visa/Discover; code above card number, upper-right hand side-AmEx): \_\_\_\_\_

Billing Address: \_\_\_\_\_  
(Street, City, State & Zip)

Signature: \_\_\_\_\_

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