



## Authorization for Credit Card Use

**It is the policy of this office to keep a credit card on file for all clients in order to ensure payment for services.**

I authorize Jacqueline Brewington d/b/a Transformative Vision to charge the credit card provided below for the following fees if I do not pay them in person when attending treatment:

- Initial Session
- Therapy session
- Late cancellation fees
- No Show/No Cancellation fee
- Returned Check Fee
- Telephone calls between therapy sessions (if longer than 15 minutes), requests for records, or collateral support services.
- Any therapy sessions or other services that are not reimbursed by insurance

I agree to pay for these purchases in accordance with the issuing bank cardholder agreement.

Client Name: \_\_\_\_\_

Name on Card: \_\_\_\_\_

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

Credit Card Type:  Visa  MasterCard  Discover  AmEx

Credit Card Number: \_\_\_\_\_

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

Card Identification Number: \_\_\_\_\_ (last 3 digits located on the back of the credit card)

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

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

I wish to receive a receipt for any payments by  Mail or  Email (check one).

Send receipt to the following address: \_\_\_\_\_

