

## CREDIT CARD PRE-AUTHORIZATION For Use By Richmond St. Counseling Center

I authorize \_\_\_\_\_  
(Provider Name)

to keep my signature on file and to charge my account for:

Payment of my session in the amount established by my provider \_\_\_\_\_  
(Amount)

- This visit only
- A Block of Sessions - specify quantity of sessions: \_\_\_\_\_
- Past Due Sessions

I understand that my card will be charged only in the event that I fail to provide payment in full by check or cash at the time of my session. I will be notified, verbally, by my provider that the past-due payment for my session will be applied to my credit card.

I also understand that if I want to use my credit card for my session (s) that I **will** make a payment prior to the session I will be attending.

I understand that this form is valid for 4 years unless I cancel the authorization through a written notice to my health care provider.

Clients Name: \_\_\_\_\_

Card Holders Name: \_\_\_\_\_

Card Holders Address: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Visa  Mastercard  Other \_\_\_\_\_

Acct. # \_\_\_\_\_ CSC # \_\_\_\_\_  
(3-digit # on back of card)

Signature: \_\_\_\_\_ Exp. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_