

CREDIT CARD PAYMENT AUTHORIZATION

As a courtesy, we offer our clients the option for their session or testing fees to be billed directly to their credit card. This form authorizes Prepare to Change to bill the below listed credit card for these services. This information is kept private and relates to services for the following:

Client Name:	Phone:
Service Type: Counseling Per Session Fee Amount	t:
Assessment One Time Fee Amount:	
Other: Fo	ee Amount: per
Please indicate the form of payment you wish to use for the above services rendered through Prepare to Change. This information will be securely stored in your clinical file and may be updated upon request at any time.	
Account Type:	☐ Amex ☐ Discover
Cardholder Name:	
Billing Address:	
Card Number:	Expiration Date: CVV Code:
I understand that it is my responsibility to notify Prepare to Change no less than 48 hours in advance if I need to cancel my appointment. If applicable, I further understand that my insurance company will not reimburse for missed appointments. Cancellations of an appointment less than 24 hours in advance and "no show" constitute a missed appointment and will be subject to a full fee for the appointment time. In the event of a late cancellation, no-show, or missed appointment, I agree to be responsible for the per session fee and authorize Prepare to Change to charge my credit card for the amounts due. I authorize Prepare to Change to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.	
My signature below indicates that I have read this Agreement and agree to its terms.	
Cardholder Signature	Date