***Credit Card Authorization***

By signing this form I am giving Angela Tracy, PsyD, MFT permission to charge my credit card the amount we have agreed to upon entering treatment as stated on the informed consent form. Angela accepts both Visa and MasterCard and Debit cards. I am giving Angela permission to charge my credit card each time we have a session and/or if I cancel or miss my scheduled appointment without giving 24 hour notice. By signing this form I am stating that it supersedes having to sign the credit card slips each time I have an appointment.

If I have any concerns about a charge I will direct them to Angela so we can clear them up. I have a choice to pay by cash or check as well but if I decide to use a credit card this policy will be in effect.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number Exp. Date 2-3 digit code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Zip code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder name Date