
Katherine Latter Counseling, PC —*seeing you through the seasons of your life*

# CREDIT CARD AUTHORIZATION FORM

Client Full Name_____ Date:_____

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 Katherine Latter Counseling, PC to charge my credit card for professional services as follows:**

**Please Initial:**

_____ I understand that I may use this card for payment by authorizing recurring charges for services in the amount of $ _____ per visit.

_____ I understand and agree that this card can and will be charged full fee of $_____ for cancellations with less than 24-hours notice and for appointments I miss, without notice, as agreed to in the client consent and professional disclosure statement, I signed.

_____ I understand and agree that this card can and will be charged for balances of charges not paid by me or my insurance (such as deductibles and copay(s).

_____ I understand this form is valid for one year, unless I cancel the authorization in writing. I will not dispute the charges ("charge back") for sessions I have received or appointments I missed according to the above policy.

**Charges will appear on your credit card statement as "Katherine Latter Counseling, PC"**

| **CREDIT CARD INFORMATION** | | | | |
|---|---|---|---|---|
| Card Type: | ☐ VISA ☐ MASTER CARD ☐ DISCOVER ☐ AMEX ☐ DEBIT | | | |
| Card # | | | | |
| | Expiration Date: | | Verification Code: | |
| Billing Add: | | | | |
| City | | State | Zip | |

_____
CARDHOLDER PRINTED NAME

_____ _____
CARDHOLDER AUTHORIZED SIGNATURE DATE

_____
CARDHOLDER EMAIL ADDRESS