

## Credit Card Authorization Form

If you know now that you would like to use a credit card to pay for my services, please provide this information below in the interest of saving time. This information will become a part of your personal and private record and therefore be protected under HIPAA guidelines.

Credit card #: \_\_\_\_\_

Security code on card: \_\_\_\_\_

Exp. date: \_\_\_\_\_

Billing zip code: \_\_\_\_\_

The undersigned authorizes The Stress Therapist, LLC to process payments to the company using the credit card number listed above. Should the card issuer not remit payment for any reason, the undersigned understands and acknowledges that he/she remains liable for unpaid amounts and may be charged for sessions that were not canceled within 24 hours of the scheduled appointment.

Signature of client:

Date:

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