

Credit Card on File Agreement

I _____ understand that my therapist has a policy that appointments must be cancelled with at least 24 hours notice. I understand that I will be charged the full fee of \$_____ for any missed appointments or appointments cancelled with less than 24 hours notice. I give permission for my therapist to use the credit card information below to cover the fee should I miss an appointment or cancel with less than 24 hours notice. I also understand this card will be used to cover unpaid and overdue fees.

Printed Name: _____

Signature: _____

Date: _____

Credit Card Information:

Card Type: (circle one) Visa, Mastercard, Discover, American Express Card

Number: _____ CVV Code: _____ Expiration Date: _____

Name on Card: _____

Address associated with card: _____
