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Credit Card Authorization Agreement

Please complete the following information. This form will be securely locked in your clinical file and may be updated upon request at any time.

I_____, authorize James Sanders, LMFT, to use my credit card information to charge my credit card in the event that I do not notify James of my inability to attend scheduled therapy appointments and/or do not cancel my appointment at least 24 hours in advance, or if a check is returned, or for any unpaid balances. The fee for a missed appointment without 24 hour notice is $175.

I authorize James Sanders, LMFT, to use my credit card information to charge my credit card to pay off my account balance. My fee is $175.- per 50 minutes.

Card Type (circle one): VISA MasterCard Discover American Express

Card #:_____Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (3 or 4 digit code on card): _____

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By signing below, I am authorizing James Sanders, LMFT to charge for missed scheduled appointments or to settle balances that are overdue.

Signature:_____Date: _____