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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.

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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.

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