

## AUTHORIZATION TO BILL CREDIT CARD ON FILE

By completing this form, you are authorizing Catherine Quinn LPCC, Inc. to bill your credit card for services rendered.

Client Name \_\_\_\_\_

Name as it appears on credit card \_\_\_\_\_

Credit Card \_\_\_ Visa \_\_\_ Mastercard \_\_\_ Discover \_\_\_ AmEx

Account Number \_\_\_\_\_

Expiration Date \_\_\_\_\_ CVV \_\_\_\_\_ Billing Zip Code \_\_\_\_\_

Permission to bill credit card account given by \_\_\_\_\_

Phone number of cardholder for any questions \_\_\_\_\_

I understand that I have given Catherine Quinn LPCC, Inc. permission to bill my credit card for services rendered. If an appointment is missed or cancelled with **less than 24 hours notice**, then my credit card will be charged for the full amount of the session, if I have not made prior arrangements.

Signature \_\_\_\_\_ Date \_\_\_\_\_