



Credit Card Authorization Form

I, _____ authorize Integrity Counseling, Inc. to charge my credit/debit
(name of client)

card for the following:

(Initial all that apply)

_____ \$_____ for all individual, couples, or family counseling/consultation sessions

_____ Copay or coinsurance rate of \$_____ for all attended appointments

_____ \$_____ for any appointment missed or canceled with less than 24 hours' notice

_____ Any portion of billable services not covered by my insurance policy

_____ Other: _____

Name Printed on Card: _____ Type of Card: _____

Credit Card Number: _____ Expiration Date: _____

CVC 3 Digit Code (back of card): _____ Billing Address Zip Code: _____

By signing below, I certify that the above information is true and accurate and that I am an authorized user on the credit card/debit account above. I authorize Integrity Counseling, Inc. to keep my credit card information on file and charge the above fees automatically and on an ongoing basis until or unless I cancel these automatic payments in writing. I understand that I am responsible for notifying integrity Counseling, Inc. if my credit/debit card information needs to be updated. Integrity Counseling, Inc. agrees to ONLY charge for services rendered or for appointments not cancelled 24 hours in advance. I understand that if I wish to cancel an appointment I will need to speak with an employee of Integrity Counseling, send an email to the correct email address of my counselor, and/or leave a recorded voicemail message at (727) 531-7988.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____