

Dr. Howard Weissman, Clinical Director

**Credit Card Authorization Form**

Client’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Todays’ Date\_\_\_\_\_\_\_\_\_\_\_

Card Number \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Expiration Date \_\_\_\_\_\_\_/\_\_\_\_\_\_/ CVC # \_\_\_\_\_\_\_\_

Card Holder’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address for Receipt of Charge \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize The Chicago Stress Relief Center, Ltd. to charge my credit card per missed appointment that is not cancelled 24-hours prior to scheduled appointment time, to the credit card listed above.

\_\_\_\_\_\_\_\_\_\_ Initial

I authorize The Chicago Stress Relief Center, Ltd. to charge any unpaid balance that is overdue by 30 days to the credit card listed above.

\_\_\_\_\_\_\_\_\_\_\_ Initial

The cardholder agrees to allow The Chicago Stress Relief Center, Ltd. to bill my credit card in full for services rendered. It is my understanding that if I terminate services without having made full payment, The Chicago Stress Relief Center, Ltd. is authorized to charge the remaining balance to my credit card.

Card Holder’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_