Ariella Goodwine Fisher, MFT

Credit Card Authorization Form

I _____, authorize Ariella Goodwine Fisher, MFT to charge the following credit card for current and future meetings and other authorized services per the informed consent/service agreement I have signed. I absolutely and unconditionally guarantee payment for any purchases made with the credit card account number identified below. I understand that my credit card will be charged the fees as agreed to in the service contract/ informed consent form. I understand that this credit card will also be charged for appointments missed or cancelled with less than 48 hours notice and that I will be charged the corresponding fee for service. I understand that if I would like to pay with cash or check, I can bring that payment at the time of any service pro in lieu of charges being applied to my credit card, otherwise my credit card will be charged. This form will be securely stored in your clinical file and may be updated upon request at any time.

_____ _____

(Signature of Card Holder) (Date)

_____

(Client Name)

Credit Card Information

Cardholder's Full Name as it appears on card:_____

Cardholder's Billing Address:_____

City:_____ State: _____ Zip:_____

Phone Number Associated with card:_____

Type of Credit Card: Visa Mastercard

Credit Card Number:_____

Security Code: _____ Expiration Date: _____