Tessa Suppes Counseling, LLC

CREDIT CARD PAYMENT AUTHORIZATION FORM

☐ I understand that I will be charged for unattended or canceled appointments if at least 48 hours' notice is not given.

☐ I understand that a discount is available to me if I pay by check, cash or ACH debit and I would prefer to pay by credit card instead.

☐ Unless I provide another form of payment, I authorize you to bill the credit card indicated below.

Credit Card Information	
Card Type:	☐ MasterCard ☐ VISA
Your Name:	_____ *Cardholder name as it appears on the card*
Billing Address:	_____
City/State/Zip:	_____ State: _____ Zip: _____
Card Number:	_____
Exp. Date: (*mm/yy*)	_____ CVV Code: _____

Services rendered/Items purchased: Psychotherapy

1. Fill out the transaction amount below.
2. Select "recurring authorization" or "one-time" authorization.

❑ Bill my charge of _____

❑ Recurring authorization as needed

❑ One-time authorization: For date(s) _____

Signature: _____ **Date:** _____

I agree to pay according to the Card Issuer Agreement.