

## **Credit Card Payment Authorization**

I prefer payment by personal checks wh card, though, I require one active Visa, N in the event that you are unable to bring	MasterCard, or Discover Card num	ber from you that may be used
I/We,	_and	
Client #1 printed name hereby authorize Allison Villarreal, LPC t session in the event that payment is not authorize Allison Villarreal to charge the appointment or initiate a schedule chan appointment time, or if I/we do not atte	Client #2 pr o charge the credit card listed bel made by cash or check at the beg credit card listed below at the ra ge less than 24 hours in advance of	rinted name low at the rate of \$150 per ginning of the session. I/We also te of \$150 if I/we cancel an
I/We understand that the amount charged, the date of charge, and Allison Villarreal's name will appear on my/our credit report, producing a record of services visible to my/our credit card company. I/We also understand that no specific content of my/our sessions (e.g. diagnosis, treatment plan, session notes) will be disclosed to billing or credit agencies without my/our signed consent.		
I/We understand that my/our credit can duration of my/our treatment and for 7 information will be shredded. I/We also all online credit card billing procedures.	years after therapy termination, a	at which point all card
VisaMasterCardDiscover		
Card Number:		
Card Expiration Date:		
Three-Digit Authorization Code from the	Back of the Card:	
Name on the Card:		
Zip Code for this Card's Billing Address:_		
	Date:	Client #1 Signature
	Date:	Client #2 Signature
	Date:	Counselor's Signature