CREDIT CARD AUTHORIZATION FORM

PLEASE FILL IN ALL REQUESTED INFORMATION BELOW

CLIENT NAME: _____

CARDHOLDER'S NAME: _____

CREDIT CARD BILLING ZIP CODE:_____

PHONE NUMBER: _____

CREDIT CARD: MASTERCARD___ VISA ___ AMERICAN EXPRESS ___DISCOVER___

CREDIT CARD NUMBER:_____

EXP.DATE:_____ CVV#: _____

I HEREBY AUTHORIZE HOUSTON PSYCHOTHERAPISTS, INC., TO KEEP MY CREDIT CARD INFORMATION ON FILE AND CHARGE MY CREDIT CARD FOR SERVICES PROVIDED.

I also authorize Houston Psychotherapists, Inc., to keep my credit card on file and charge my credit card for the cancellation fee ($50.00) for any appointment missed or canceled with less than 24 hour notice as well as for any outstanding balance upon termination. I understand that this authorization is valid for one year unless I cancel the authorization through written notice to Houston Psychotherapists, Inc.

CARD HOLDER'S SIGNATURE:_____

DATE: ___/___/_____