# Authorization for Credit Card Use for Last-Minute Cancellations and No-Shows

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN

**All Information Will Remain Confidential**

Name on card: ___________________________________________________________

Billing Address: ___________________________________________________________

Card Type: _______ VISA _______ Mastercard _______ Discover

Credit Card #: ____________________________________

Expiration Date: ___________________________________________

Card Identification Number: ________ (last 3 digits located on the back of the credit card)

Amount to Charge: $ ________________ (USD)

I understand that my credit card will only be charged in the event that I do not provide my therapist with adequate 24-hour cancellation notice or fail to show up for a scheduled session without prior cancellation, and that I will be charged the full amount of my session. I also understand and agree that this form may be submitted to the bank/credit card company in the event of any credit card disputes over my session charge that result in attempted charge backs. I authorize Grace P. Ravenelle, LCPC to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: ___________________________________________

Date: _______________________________________________

Print Name: __________________________________________