DeLuca Counseling, Inc., Credit Card Authorization Form

I hereby authorize DeLuca Counseling, Inc., to keep my credit or debit card information on file and to **charge my card $75 in the event that I fail to show for a scheduled appointment or do not provide at least 24 hours notice if I need to cancel an appointment**. I understand I will not be charged in the case of illness, emergency, inclement weather or natural disaster, or other extenuating circumstances if this is clearly communicated to my therapist via text message, voice mail or email. I understand this authorization is valid until canceled in writing. I understand this information will be securely stored and I will only be charged in the above mentioned circumstances.

CLIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fill in details as indicated below:

CARDHOLDER NAME AS APPEARS ON CARD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CREDIT CARD NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXPIRATION DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV 3 DIGIT CODE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BILLING ZIP CODE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CREDIT CARD TYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_