Credit Card Pre-Authorization Form

Patient Name:_____ Date:_____

Patient D.O.B.:_____

Patient Address:_____

The undersigned Patient/Cardholder hereby authorizes Sondra Wilkinson, LPC to obtain payment of fees for services from the Patient/Cardholder's credit card account identified below. Sondra Wilkinson, LPC may charge the account for missed appointments (minimum 24 hours notice cancellation notice is required), without requirement of the Patient/Cardholder's signature for each payment. A receipt of the transaction with be mailed to the address provided by the Patient/Cardholder above.

By signing this form, the client/cardholder acknowledges and agrees as follows:

*This signed form is confidential and will be kept on file at Aspire Growth Counseling.
*The Patient/Cardholder authorizes Aspire Growth Counseling to automatically charge the below referenced credit card any remaining balance on the above named patient's account (including co-pays, co-insurances, deductibles, or missed appointment fees).
*The Patient/Cardholder certifies, warrants, and represents that the cardholder named above agrees to pay the credit charge(s) in accordance with agreement described above.
*Credit card payments will appear on your statement as Sondra Wilkinson, LPC or Aspire Growth Counseling.
*If the Patient/Cardholder fails to dispute a charge within 30 days from the time the Credit Card is charged, the Patient/Cardholder agrees the charges are valid and agrees not to dispute said charges.
*This authorization will remain valid for 12 months and will automatically renew on an annual basis, unless revoked in writing with 30-day notice of revocation.
*This authorization serves as an agreement for receipts to be noted "signature on file" when charged.

PLEASE CIRCLE ONE: Visa MasterCard Discover

Printed name on card:_____

Credit Card Number:_____

CVV Number:_____

Expiration Date (Month/Year):_____

Patient/Cardholder Authorized Signature:_____