



Permission To Use Credit Card

For your convenience, we have implemented a policy which enables you to maintain your credit/debit card information on file with us.

I hereby authorize the Family Center, LLC to keep my Card information on file for payment of charges for services for which I am financially responsible. I understand that the Family Center LLC will send me a receipt reflecting any amount charged to my Card. If my Card information change for any reason, I will notify The Family Center, LLC.

Whenever I am not present to pay in person at the time of service, please **charge fees associated with the following patients**. This includes charges for missed sessions not cancelled within 24 hours of the appointment time.

I also understand that group therapy sessions are charged by the month at the beginning of each month. (Example: If a month has 4 sessions, I will be charged for all 4 sessions at the beginning of the month.)

Name on Card: _____

VISA/Master/Discover Card (AMEX not accepted)

Enter entire credit card number:

Billing Address on Card:

Street

City State Zip

Expiration Date of Card: _____ CVC Code on back of card: _____

Cardholder Signature: _____