PRE-AUTHORIZED HEALTH CARE FORM

I authorize the practice of Associates in Professional Counseling & Coaching to keep my signature on file and charge my credit card account for:

- Charges for appointments attended (fees for services rendered)
- Charges for missed appointments (including those not canceled within 24 hours as well as no-show's)
- Balances of charges not paid to APC within 90 days

I understand that I may revoke this agreement at any time by providing a request in writing.

Client Name: _____

Cardholder's Name: _____
As it appears on the card.

Cardholder's Address: _____

_____
City *State* *Zip*

Credit Card: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Account Number: _____

CVC - Code Number: _____
on back of card

Expiration Date: _____

Signature: _____

Today's Date: _____

E-mail Address: _____
Note: E-mail is not a secure form of communication and confidentiality cannot be guaranteed. By listing your e-mail address here, you are giving consent of this communication.

Associates in Professional Counseling & Coaching agrees to charge only for reasons stated above at agreed upon rates per our commitment.