ascend
family institute

Credit Card Authorization

You are welcome to pay for sessions with cash, check, or credit card. Please be assured that your information will be kept safe and strictly confidential.

Please choose one or more of the following options:

_____Please charge my card for the following amount: $______________ for the following reason: ____

_____Please charge my card to replenish my reunification therapy retainer as necessary

_____Please charge my card for my sessions as they occur and any other fees that I incur

_____Please charge my card on the ________ day of each month for my entire balance

CREDIT CARD INFORMATION

First Name (as it appears on card): ____

Last Name (as it appears on card):____

Card type (circle one): Visa Master Card Discover American Express

Card number: ____

Expiration Date:___________(mm/yy) Security Code:______ (three-digit number printed on back of card)

Billing Address:____

City, State, ZIP:____

Email address:________________________________ Telephone:____________________

I understand that if I fail to make payments owed for attended sessions, if I do not attend a scheduled session, or if I cancel a session less than 24 hours from the start time of the session, and do not make the required payment(s) within 7 business days, Ascend Family Institute, LLC has my permission to charge the card listed above accordingly. I understand that if I am having difficulty paying I can speak with my therapist about alternative arrangements.

Card Holder's Printed Name: ____

Card Holder's Signature: _________________________________ Date: ________________

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