CREDIT CARD PRE-AUTHORIZATION

FIONA STEELE, LMFT

I authorize Fiona Steele, LMFT, to keep my signature securely encrypted on file and to charge my account for psychotherapy session.

I agree to notify Fiona Steele if my credit card information changes during the course of therapy and that there are sufficient funds to cover each charge.

CLIENT's NAME: _____
(as it appears on the credit card)

CARD HOLDER'S NAME: _____
(if different from above)

CARD HOLDER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL: _____

VISA _____ MASTERCARD _____ AMERICAN EXPRESS _____ OTHER _____

CARD HOLDER'S PHONE #: _____

ACCT#: _____ 3 DIGIT CODE: _____

EXPIRATION DATE: _____

SIGNATURE: _____