Credit Card Authorization

Please complete the following information.

I, ____[print cardholder name], am authorizing Aspire Mental Health and Wellness LLC to charge my credit card for any services rendered as agreed to in the Office and Practice Policies and Informed Consent document. I also authorize Aspire Mental Health and Wellness LLC to charge my card in the event that ____ [print client name if different than card holder] fail(s) to show for a scheduled appointment, or do(es) not give notification of the inability to attend a scheduled appointment at least 24 business hours in advance. Furthermore, for outstanding payments of service rendered, I authorize Aspire Mental Health and Wellness LLC to charge my credit card for the full amount due. I will not dispute for sessions I have received or that I have not cancelled less than 24 business hours in advance.

I also authorize Aspire Mental Health and Wellness LLC to disclose information about my attendance/cancellation to my credit care company if I dispute a charge.

I acknowledge that I am aware there is a $25.00 fee for any declined credit card charge.

Card Type (circle one): Visa MasterCard American Express Discover Card

Card #: ____ Exp Date: _____/_____ CCV#:__________

Name as Printed on Card: ____

Client Name: __________________________________ Relationship to client: _________________________

Billing address of card holder:____
(Street, City, State, & Zip Code)

Signature: ____ Date:______________________________
(Client or Financially responsible party)

This document will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will NOT be charged unless the following conditions apply: Failure to show up for a scheduled appointment, cancellation less than 24 business hours in advance, or participation in treatment without payment rendered.