Credit Card Authorization Form
Cancellation Policy

PLEASE COMPLETE THIS AUTHORIZATION AND RETURN TO US.
All information will remain confidential.

Cardholder Name: ____

Billing Street Address: ____

State: ________________ Zip Code: ___________

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ American Express

Credit Card Number: ____

Expiration Date: ____

Security Code: ____

Charge Amount: $ _50.00__ (USD)

I authorize ___FAMILY CHOICES COUNSELING CENTER __ to charge the agreed amount listed above to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement if I do not give 24 hours notice to a canceled appointment, or I no-show for an appointment. I understand that the voice mail system has date and time stamp so there is no question as to the time I left a voice message cancelling my appointment.

Cardholder –Sign, Date and Print Below:

Signed:____

Dated: ____

Name: ____