Credit Card on File

Client Name: ______________________________________ **Date of Birth**:____________________

The information gathered below is used for the purpose of service fees/co-pays/deductible payments/co-insurance and missed appointment payments incurred at Thriving Lives Counseling, LLC at the time of service. Please complete the form below. **This card will be kept on file and charged within 24 hours of your appointment unless you make other arrangements with us. A minimum of 24 hours notice is required for rescheduling or canceling an appointment. If proper notice is not given for the rescheduling or cancellation of any appointment, a $100 fee will be charged.**

Date: _________________________

Card type (Circle One): Visa/MC/Amex/Discover

Cardholder Name: ____

Phone Number: ____

Card Number: ____ Expiration Date: _____ /_____

Security Code: ______________

Billing Address: ____

____

Billing Zip Code: ______________________

Cardholder Signature: ______________________________________ Date: ___________________

By signing, you are providing permission for payments to be drafted from your account and applied toward the above person's account.