

Rachael Rutter DeKoning, LCMFT, LLC

Credit Card Authorization Form

Your group therapist requires a credit card on file. The credit card will be automatically charged at the end of sessions as outlined in the consent form. When paying at the time of service, you can pay with cash, check, or card.

Today's Date: ____ - ____ - _____

Your Name: _____

Payment Agreement

Credit Card Information and Authorization

Name as it appears on the card: _____

Type of card: Visa Mastercard

Credit card number: ____ - ____ - ____ - ____

Security Code: ____ Expiration Date ____

Street: _____

City: _____ State: _____ Zip code: _____

Phone: _____

I hereby authorize this card to be used for service charges at Rachael Rutter Dekoning, LCMFT, LLC.

Cardholder signature: _____ Date: _____

Signature

I understand and agree to the terms and conditions on this form.

Patient Signature: _____ **Date:** ____/____/____