Counseling Recovery
HELPING YOU HEAL HABITS THAT HURT

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Automated Credit Card Permission Form

Date: _____ Name of patient: _____

Name of person on the credit card: _____

Check type of card:

American Express: _____Discover: _____MasterCard: _____Visa:_____

Account #: _____ Expiration date on card _____

CSC # (3 number on the back of your card) _____

If American Express four digit on front _____

Phone Number _____ Email: _____

Billing address on credit card:

_____
(Street address)

_____ _____ _____
(City) (State) (Zip code)

I give Michelle Farris at Counseling Recovery permission to charge the above credit card for the cost of each session and for any cancellations made after 24 hours notice.

_____
Signature of person on credit card.