

Elizabeth Cappelletti, M.A.
 Licensed Marriage & Family Therapist # MFC 48524
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Credit Card Payment Authorization

I hereby authorize and direct Elizabeth Cappelletti to charge my credit card at the then current fee rate for all services that are scheduled for the below named client.

Name of Client: _____
First Last MI

I Understand that I will be responsible for full payment on all scheduled appointments, unless notice of cancellation is received by Elizabeth Cappelletti more than 24 hours in advance of the appointment. If there is difficulty in processing payment through the specified credit card, I agree to provide payment-in-full through other payment means. My authorized credit card information is as follows:

Credit Card Type (Circle one): Visa MasterCard Discover

Name as it appears on card: _____

Credit card number: _____

Credit card Expiration: _____ CVC (3 or 4 digit code): _____

Credit card billing address: _____
Address City State Zip

This authorization shall remain in effect for two full years from the date of signing. This authorization may be revoked by written notice only. Notice of revocation is effective upon receipt by Elizabeth Cappelletti. Revocation of this agreement does not, in any way, revoke or invalidate credit card transactions that were initiated prior to receipt of revocation. Once completed this form may be brought to Elizabeth Cappelletti's main office. Please do not email credit card information over the internet.

If any provisions of this authorization is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provisions.

By my signature below, I certify that I have read, understand, and agree to all aspects of this authorizations.

Signature

Date

Printed Name