

ALEXINE THOMPSON-DE BENOIT, LMFT

CREDIT CARD AUTHORIZATION AGREEMENT

**Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.
In case of late cancellations and/no shows for scheduled sessions, or if a check is returned unpaid, you will be charged the full session fee. An additional \$25 will be assessed for returned checks.**

I, _____, am authorizing Alexine Thompson-de Benoit, MFT, to use my credit card information to charge my credit card through PayPal in the event that I do not notify her of my inability to attend scheduled therapy appointments and/or do not cancel my appointments at least 24 hours in advance, or if a check is returned for any reason, as agreed to in the signed Informed Consent form. I will not dispute charges (“charge back”) for sessions I have received or appointments I have missed according to the above policy.

Card Type (circle one): Visa, MasterCard

Card # _____ Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (3-digit code on back of card by signature line): _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Print Name: _____

By signing below I am authorizing Alexine Thompson-de Benoit to charge for missed scheduled appointments.

Signature: _____ Date: _____