**IntraSpectrum Counseling**

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866-883-4392

## 2. Credit Card Authorization

Client Name:

Cardholder Name:

Card Number:

Card Expiration:

Security Code (CVV):

Zip Code affiliated with the card:

I authorize IntraSpectrum Counseling, Ltd. to charge my credit/debit/health account card for professional services. I understand that if I do not comply with IntraSpectrum Counseling, Ltd.'s cancellation policy, IntraSpectrum Counseling, Ltd. will charge my card as a late cancel or no show according to the rates provided in the cancellation policy, which I understand and agree that IntraSpectrum Counseling, Ltd. may change or modify in its sole discretion upon written notice to me.

I verify that my credit card information, provided above, is true and correct. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance may sent for collection if another alternative payment is not made within thirty calendar days.

Client Initials:

Card holder Initials (If different than client):

Date:

Signature (Type your name using /John Doe/ format):