

Lifestyle Center for Counseling & Nutrition



ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted in order of clinician preference: Cash, Check, **Visa, MasterCard, Discover**. This information will be securely stored in your clinical file and may be updated upon request at any time. Please be aware that transactions will appear as "Therapy Partner" on your bank or credit card statement. Per office policy and to protect clinician in event of a No Call No Show, or Late Cancellation all client's must have a credit card on file.

Contact Information:

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Number: _____ Mobile Number: _____

Email: _____

Preferred Payment Type (check one):

Cash _____ Check _____ Credit/Debit Card: _____

Credit/Debit Card Information:

Card Type (circle one): Visa MasterCard Discover

Card Number: _____

CVV: _____

Expiration Date: _____

Account Holder Information:

Please indicate the name and address associated with the credit card or bank account you wish to use.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Signature of Client or Legal Guardian

Date

Please return this form to your therapist