



CREDIT CARD AUTHORIZATION FORM

FOR USE BY INSTITUTE OF MODERN RECOVERY

I authorize _____
(Provider Name)

To keep my signature on file and to charge my account for:

Payment of my session in the amount established by my provider _____
(amount)

- ✓ For a No- Show or missed session without a 24 hour cancellation notice.
- ✓ For past due session.

I understand that my card will be charged only in the event that I fail to provide payment in full at the time of my session/ missed session. I will be notified, verbally, by my provider that the missed session or the past due session payment will be applied to my credit card.

I agree that this form is valid for the length of therapy and authorization for the use of this card will be canceled at the termination of therapy.

Client's Name: _____

Card Holder's Name: _____

Card Holder's Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Visa Master Card American Express

Acct. # _____ CSC# _____

(3-digit # on back of card)

Signature: _____ Exp. Date: ____/____/____

PLEASE PRINT ALL INFORMATION LEGIBLY & COMPLETELY.