

DANIEL GARCES
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Licensed Marriage & Family Therapist
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CREDIT CARD AUTHORIZATION FORM

Please Print

Credit card billing information:		
Name:		
Email Address:		
Credit card type:	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express	
Credit Card #:		
Enter cvc #:	For Visa and MasterCard, the last 3 digits on back of card: For American Express, the 4 digits on face of card:	
Expiration Date:		
Billing Address:		
City:		
State:		
Zip Code:		
Phone Number:		
Please select one of the following payment options:		
Once	Bill my credit card <u>once</u> for the following amount:	\$
	Bill my credit card <u>each visit</u> for the following amount	\$
	Bill my credit card for <u>each missed</u> appointment for the following amount:	\$ 175
Monthly	Bill my credit card once per month for the following amount:	\$
I agree all information provided is accurate and complete. I also acknowledge services may be immediately terminated at Daniel Garces, MS, LPC, LMFT's discretion if any charges are declined or charge backs are claimed against any outstanding amount. Disputes to amounts should immediately be reported to Daniel Garces, MS, LPC, LMFT. Likewise, changes in the status of this card can also be reported to Daniel Garces, MS, LPC, LMFT.		
The undersigned is the dully-authorized representative of the above cardholder.		
Authorized Signature:		Date: