

CEDAR VALLEY COUNSELING SERVICES

Electronic Payment Authorization

Please indicate the card you wish to use for all services rendered through Cedar Valley Counseling Services. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept most major credit cards.

Client Information

Client Name: _____ Date of Birth: _____

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

Home Number: _____ Mobile Number: _____

Email: _____

Billing Information

Please indicate the information associated with the card you wish to use.

Name on Card: _____

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

Email: _____

I authorize all service fees to be deducted from the card **ending in** _____ (last four digits of the card) and **CVV code** _____ (last three digits on back of card) for the following parties:

Client(s) full name(s): _____

I authorize my provider and Cedar Valley Counseling Services to charge my credit/debit/health savings account card for professional services. I recognize that if I do not cancel my appointment 24 hours prior to my scheduled appointment, CVCS can charge my account as a late cancel or no show if I do not show up for my scheduled appointment at \$40 per session.

*By signing this electronic payment authorization form, I certify that I am the cardholder and that the information provided is accurate to the best of my knowledge.

Cardholder Signature

Date

Payments are processed by Stripe. Your credit card statement should reflect payment to CEDARVALLEYCOUNSELING.

Card Information

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

☐ Credit ☐ Debit ☐ Health Savings

Card Number: _____ Expiration Date: _____