

Credit Card Authorization

I authorize LifeWorks Psychotherapy Center to keep my credit card information on file and to directly charge my credit card account for:

_____ Charges I personally incur.

_____ Charges incurred by the following person(s): _____

CREDIT CARD INFORMATION

Credit Card Number _____

Check box if this credit card is attached to an HSA or FSA

Expiration Date _____ 3 Digit Security Code _____

Card Holder's Name _____

Email _____

Phone Number _____ Zip Code _____

Card Holder's Signature _____

Date _____

*Cancellation Courtesy

The courtesy of 24-hour notice of cancellation of scheduled appointments is requested. Clients will be held responsible for their full session fee, if 24-hour notice is not given to their therapist. Please note your insurance carrier cannot be billed for a cancellation and you will be responsible for the cancellation fee for missed sessions. Insured clients are charged \$150 for each missed session.