

Authorization for Automatic Debit/Credit Card Payment

Clients Name: _____

Parent/Guardian Name: _____

Date: _____

By my signature below I authorize Family Fusion to debit/charge the account I have specified below for the contracted amount. I understand that my account will be charged the week of the appointment. Missed appointment fees will also be assessed to my account. One week's written notice will be necessary to cancel this authorization.

A credit card/debit receipt will be issued after each session as documentation for your records. A signature will be required on these receipts.

DEBIT/CREDIT CARD AUTHORIZATION

Please circle the card type: VISA / MASTERCARD / DISCOVER CARD

Name as it appears on the card: _____

Charge #: _____

Exp. Date: _____ CVV2#: _____

First 4 numbers of your billing address: _____

Zip Code for billing address: _____

Signature: _____

Home Phone: _____ Work Phone: _____