CLEAR VIEW COUNSELING CENTER
Guiding your way to wellness

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Credit Card/ Debit Card Authorization Form

By signing this form, you may authorize fees related to your therapeutic services to be deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card.

Please provide the following information:

I, _____ authorize Clear View Counseling Center, LLC, to charge my
(print name)
credit/ debit card for the amount of my co-payment, following each appointment for the payment of my therapy session.

Billing Address: _____
Street Address Apt #

_____
City State Zip Code

Phone Number: _____-_____-_____ Email:_____

Credit/ Debit Card:

☐ Visa ☐ Master Card ☐ American Express ☐ Discover

Cardholder Name: _____

Account Number: _____ Expiration Date: _____

CVV (3 Digit Number on Back of Card): _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Clear View Counseling Center, LLC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. In the case of a transaction being rejected for Non Sufficient Funds (NSF) I understand that Clear View Counseling Center, LLC may at its discretion attempt to process the charge again within 30 days, and agree to an additional $35 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.