Andrea Guzman, LMFT MFC45958

4452 Park Blvd. #204

San Diego, CA. 92116

**Credit Card Authorization Form**

Normally I would collect copays or charges at the beginning and end of a therapy session using your preferred payment method. However, in the event of non-payment of fees, whether this is for copays that go unpaid, charges accumulated for not showing to a session, or late cancelations (less than 24 hour notice), we may need to charge a credit card. By signing this form, you hereby authorize Andrea Guzman, LMFT, to charge this credit card in the event of non-payment of fees. You also authorize this information to be saved to your confidential file. If you do not want this card charged, please speak with me about a payment plan for unpaid balances and I will do my best to accommodate.

Credit Card Information

Card Type: VISA MasterCard Discover Other:

Cardholder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date (mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CCV (3 numbers found on the back of your card): \_\_\_\_\_\_\_\_

Cardholder’s ZIP code (credit card billing address): \_\_\_\_\_\_\_\_\_\_

Signature of client (or person acting for client) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_