CREDIT CARD AUTHORIZATION FORM

Please fill in the information & sign below:

Print Name: ____

Phone Number: ____

Email: ____

Credit Card Type: ☐ Debit ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Credit Card Number: __________ - __________ - __________ - __________

Expiration Date (mm/yy): _________ /_________ Security Code: _________

Name as it appears on your card: ____________________________________

Billing Address: ____

City: _____________________________ State: _______ Zip: ____________

In signing below, I authorize Tides Counseling, LLC to initiate a recurring charge to the credit card indicated above for the total amount due at the end of each session. I also agree to the payment terms established on the new patient consent form outlining the cancellation and no-show policy reprinted below, as well as any additional charges related to services provided.

If you cannot keep the scheduled appointment, you MUST notify my office to cancel or reschedule the appointment within 24 hours of the scheduled appointment time. If you give less than 24 hours notice, you are responsible for 50% of your fee unless I am able to fill the hour. If you are a no-show to your appointment, you are responsible for payment of your regular full fee.

I understand that I may modify or cancel recurring charges upon written or verbal notice at any time prior to services rendered or scheduled.

Cardholder Signature: ____

Date: ____________

Highly Confidential

PAIGE E. FANT, LCSW, MCAP, ICADC
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Florida License #SW15154

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