TIDES COUNSELING

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 or are a no-show to your appointment, you are responsible for 100% 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
Provider NPI #1669960373
Florida License #SW15154

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