325 Forest Grove Drive, Suite 201, Pewaukee, WI 53072
www.lighthousecounselors.com
Fax 262-691-2972

CREDIT CARD AUTHORIZATION FORM

Therapist Name _____

Patient Name _____ Patient DOB_____

Name on Card _____

Type of Card (circle one) MC VISA DISCOVER AMEX OTHER

Card Number _____

Expiration Date _____

Security Code (3 or 4 digit) _____

Billing Address _____

City/State/Zip _____

Phone Number _____

By signing this form, I authorize the above-designated therapist at the above-designated location to charge my credit card for services provided as agreed upon during the informed consent process.

Signature of Cardholder _____

Date _____

You retain the right to revoke this authorization.
This authorization will remain in effect until written notice is provided.