



TherapyCanHelp.org

A 501(c)(3) Non Profit Organization

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CLIENT CREDIT CARD AUTHORIZATION

Client Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Credit Card Information

Card Number: _____

Expiration Date: _____

Security Code: _____

Zip Code: _____

Name on Card: _____

Therapy Can Help, NFP will keep this information private. It will not be used without prior authorization of the above client.

_____ (name) agrees to provide this information for payment purposes to Therapy Can Help, NFP.

This card will be charged should payment not be received by late payment date or if notice of late payment has not been received, for balance due at that time. This card may also be charged for missed appointments, or appointments canceled with less than 24 hour notice.

I fully understand and agree to these terms.

Client Signature: _____

Date: _____