



HEART | MIND
THERAPY

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization in writing at any time. The authorization will remain in effect until it is canceled.

CREDIT CARD INFORMATION

Card type:

Cardholder Name (as shown on card):

Card Number:

Expiration Date (MM/YY):

CVV:

Cardholder 's complete billing Address:

I, _____, authorize Dr. Jana Corbett to charge my credit card above for agreed upon purchases for on _____ 's account, including but not limited to deductibles, and co-pays for any services provided, full session fees for self-pay appointments, late cancellation/ no show fees and any outstanding balances. I understand that my card will be charged at the time of the appointment, typically at the beginning of the session to ensure payment. I understand and agree that my information will be kept on file for future transactions on this account. I understand and agree that my therapist may charge my card without me being physically present, for example in the case of my missing an appointment.

Printed Name

Signature (You may sign electronically through the client portal).

Date