Dayspring Center for Christian Counseling
123 Sand Mountain Dr NW
Albertville, AL 35950

Permission to Charge
Credit Card Information

Cardholder Name (as it appears on card):_____

Billing Address:_____

City:_____State_____Zip_____

Card Type:

0 American Express 0 Discover 0 MasterCard

0 Visa 0 HSA 0 FSA

Card Number:_____

Expiration Date (MM/YY):_____

CVV:_____

Authorization & Agreement
I authorize Dayspring Center for Christian Counseling to charge my credit card for any services provided that are not covered or reimbursed by my insurance provider, including but not limited to: session fees, co-pays, late cancellation or no-show fees, and outstanding balances.

This authorization will remain in effect until I provide written notice of cancellation. I understand I may request a receipt for any transaction processed with this card.

REQUIRED SIGNATURE
By signing below, I acknowledge that I have read, understand, and agree to the terms of this authorization.

Client Printed Name_____

Date_____

Client Signature_____