Matthews Counseling, LLC
Chester Springs, PA

Credit Card Authorization Form

I hereby authorize my provider to keep my credit card number on file and to charge the usual fee for services rendered at the time of service. This is done as a convenience, saving session time and so you do not have to bring payment to each visit. I also understand that per Matthews Counseling policy, I will be charged the usual fee in the event of missed sessions (late cancelations or no-shows) at the would-be time of service. My provider will keep my credit card information in a locked and secure file for the duration of treatment, and at the time of discharge and when all outstanding fees have been paid, this information will be shredded. It is my responsibility to update this information with my provider, should my card expire, be canceled, or should I choose to use an alternate form of payment. Should I do so, any previous forms on file will be shredded.

**You may sign and submit this form, giving your provider the card information by phone or in-person if you do not wish to send this information electronically. However, your signature is required if you want to keep a card on file.*

Type of card:

VISA	_____	MASTERCARD	_____
AMEX	_____	DISCOVER	_____
OTHER	_____		

Card number: _____ Expiration (MM/YY): _____

Security code: _____

_____ _____

Cardholder signature Date

_____

Cardholder printed name