Credit Card Payment Authorization

As part of receiving services, I understand and authorize the following:

- Aspire Within Psychotherapy to charge my copayments, cancellation/no-show fees, and balances due to my credit card
- I will be charged prior to the start of each visit for the copayment that is due
- The charge will appear on my credit card statement. A receipt can be sent to me upon my request.

Please complete the following information:

I, _____ ,authorize Aspire Within Psychotherapy to charge my credit card indicated below for payment of my applicable copayments, cancellation fees, and balances due. I understand that this authorization will remain in effect until I cancel services with Aspire Within Psychotherapy. I agree to notify Aspire Within Psychotherapy of any changes in my account information, or termination of this authorization. I certify that I am an authorized user of this credit card, and will not dispute the scheduled transactions with the credit card provided.

Name on Card: _____ Expiration Date: _____

Credit Card #: _____Security Code: _____

Billing Address: _____

Signature:_____Date:_____