

RECURRING CREDIT CARD PAYMENT AUTHORIZATION



Professional Counseling,
Consulting & Educational Services

www.lifestrategyconsultants.com

Phone: (717) 376-3075

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You authorize regularly scheduled charges to your credit card. You agree that no prior-notification will be provided. If the credit card is declined for any reason a bill will be mailed to the address provided.

I _____ authorize LifeStrategy Consultants to charge my Credit Card indicated below for fees from services rendered including (Please place your initials next to each item):

- _____ Co-Pays
- _____ Co-Insurance
- _____ Deductibles
- _____ Late Cancellation Fees
- _____ Testing/Assessment Fees
- _____ Material resources

As determined by my insurer and in agreement with the Client Agreement, Indemnity, & Consent for Treatment Form provided between the 10th and 15th of each month.

Billing Information

Billing Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Email Address _____

Card Details Visa MasterCard

Cardholder Name (Printed) _____

Card Number _____

Expiration Date _____ / _____ (MM/YY)

CVV/Security Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify LifeStrategy Consultants in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

Cardholder's Signature _____ Date _____