Lind Butler, MEd, LPC

Credit Card Authorization Form

Instructions: Please fill out the form completely. Please do not omit any fields. Please sign, date and bring this document with you to the first session.

I hereby authorize Lind Butler, MEd, LPC and her representative to keep my signature on file and to charge my credit card account for psychotherapy services and late cancellation fees, when applicable. These services can include my participation in individual, couples, family or group psychotherapy, telephone consultation or coaching sessions.

For these services I authorize Lind Butler, MEd, LPC and her representative to charge the credit card listed below in the amount of the contracted hourly session rate. I understand that if I decided to terminate any of the services and my account is paid up in full, I may withdraw the authorization to charge my credit card in the future provided I communicate revocation of authorization in writing to Lind Butler, MEd, LPC by mail or in person.

Please print legibly

Client Name: _____

Card Holder's Name (as it appears on the card): _____

Credit Card Billing Address (the address that the credit card bill is mailed to)

Street Address: _____Unit #: _____

City, State, Zip code:_____

Credit Card Type: Visa_____Mastercard_____ Discover_____AMEX_____

Credit Card Number: _____

Expiration Date: _____

CIN (CID/CVV2/CVC2-the three digit code on the back or the four digit code on the front of the card): _____

Signature: _____