CREDIT CARD AUTHORIZATION

IT IS REQUIRED THAT ALL CLIENTS KEEP A CREDIT CARD OR DEBIT CARD ON FILE. THIS MUST BE COMPLETED PRIOR TO THE FIRST SESSION.

NAME: ____ DATE:____________________
CREDIT CARD NUMBER: ____ EXP. DATE: _______________________

I AUTHORIZE THAT MY CREDIT CARD MAY BE CHARGED BY WOMEN'S THERAPY CLINIC AUTOMATICALLY FOR ANY SESSION I DO NOT ATTEND WITHOUT GIVING 24 HOURS NOTICE.

SIGNATURE: ____