VITAL INSIGHT COUNSELING

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CREDIT CARD PROCESSING AGREEMENT

Name as it appears on card: _____
(First) (M.I.) (Last)

Circle one: VISA Mastercard Discover American Express

Credit card number: _____

Expiration Date: _____ Billing Zip Code:_____
Ex. (04/13)

CSC code (back of card):_____

Please recall the 24-hour cancellation policy, which states that you will be charged the full fee of $125 for missed appointments and cancellations made within 24 hours. Your insurance company will not cover your missed appointment. By signing this agreement, you agree to the terms stated here and authorize Vital Insight Counseling to charge this credit card for the full fee of $125.

Client/Guardian Signature _____ Date _____

Therapist's Signature_____