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CREDIT CARD PROCESSING AGREEMENT

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.

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: _____ CSC code (back of card): _____

Client/Guardian Signature _____ Date _____

Client/Guardian Signature _____ Date _____

Therapist's Signature _____