Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____/_____ Three-digit security code _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize Cordell Associates, LLC to charge my credit card after each therapy session. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Client Name Client DOB

_____ _____
Client/Guardian Signature Date