Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time. 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: ________________________________ **CVV**:___________
Expiration Date (mm/yy): ________________________________
Cardholder ZIP Code (from credit card billing address): ________________________________

By signing below you authorize AGAPE to charge your credit card to pay for:

- Counseling or psychological services received
- Missed appointments or appointments which were cancelled with less than 24 hours notice (See Therapist-Client Agreement for details)
- Outstanding balances

I,_______________________, authorize AGAPE to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

__________________________________ __________________________________

Customer Signature **Date**

4555 Trousdale Drive, Nashville, TN 37204 ● Phone: 615-781-3000 ● Fax: 615-781-8262