CREDIT CARD AUTHORIZATION AGREEMENT

All fields are required to be completed on this form

_____

Client's Name(s) (Print)

Credit Card Information: (as shown on credit card)

Credit card type: Visa MasterCard Discover Amex Other: _____

Card Holder Name (as shown on credit card): _____

Credit Card #:_____Expiration Date: _____/_____
MM YY

Security Code:_____

Billing Address of Card Holder: _____
street address

_____
city state zip

Phone Number of Credit Card Holder: (_____)_____

Do you want to receive an email receipt? Yes No
If yes, please provide your email address here: _____

Authorization:I hereby authorize Lisa Senatore, Ph.D., PLLC to charge the indicated credit card on a periodic basis to collect payment due for services rendered by in accordance with the Fee Schedule for the above listed client. I also authorize Lisa Senatore, Ph.D., PLLC to charge my credit card the cancellation fee, in accordance to the Fee Schedule, should the above listed client fail to attend their scheduled appointment or fail to give a 24 hour notice to cancel their appointment. If Lisa Senatore, Ph.D., PLLC is unable to process my payment, I will be responsible for an alternate payment arrangement and all late fees that occur. I understand that this agreement shall remain in force unless I cancel it in writing. I will not dispute Lisa Senatore, Ph.D., PLLC's charges to my credit card so long as the amount in question is for services rendered prior to my canceling my agreement in the manner required. I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this agreement with Lisa Senatore Ph.D., PLLC. I acknowledge that I have read and agree to all of the above terms and conditions.

_____ _____

Signature of Credit Card Holder (Required) Date