Dr. Howard Weissman, Clinical Director

# Credit Card Authorization Form

Client's Name:________________________________ Todays' Date___________

Card Number _______-________-________-________
Expiration Date _______/______/ CVC # ________
Card Holder's Name____________________________
Billing Address:
_________________________________
_________________________________

Email Address for Receipt of Charge _____________________________________

I authorize The Chicago Stress Relief Center, Inc. to charge me per missed appointment that is not cancelled 24 hours prior to scheduled appointment time, to the credit card listed above.
__________ Initial

I authorize The Chicago Stress Relief Center, Inc. to charge any unpaid balance that is overdue by 30 days to the credit card listed above.
___________ Initial

The cardholder agrees that The Chicago Stress Relief Center, Inc. will bill the subscriber's credit card. It is my understanding that if I terminate services without having made full payment, The Chicago Stress Relief Center is authorized to charge the remaining bill on this credit card. Thank you for your cooperation.

Card Holder's Signature__________________________________ Date_________________