CARD AUTHORIZATION

(Debit, Health Savings, Master Card, Visa, no AMEX)

I authorize Monica Hurt, LMFT to keep my signature on file and to charge my card for balances remaining after therapy sessions.

This authorization shall be valid for the length of treatment with Monica Hurt, LMFT or until canceled by me.

The following are covered under this agreement and can use this card for services:

Name (print) _____

Name (print) _____

CARDHOLDER Name (print) _____

Address & ZIP _____
(where card statement is sent)

CARD NUMBER

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

EXPIRATION DATE

☐☐/☐☐

Month Year

SECURITY CODE
(3 numbers on back of card)

☐☐☐

CARDHOLDER Signature _____

DATE _____

Monica Hurt, LMFT
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monicahurtmft@gmail.com