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Credit Card Authorization Form

Name on card _____

Card Type ___ Visa ___ MasterCard ___ Discover ____ American Express

Card Number _____

Expiration Date _____ Security Code (3 digits) _____

Billing Zip Code _____

I authorize charges for any session, account balances, and/or session cancellation fees (less than 24 hour notice). Fee is _____ per session.

Signature of Cardholder _____

Name of Client _____

Date Signed _____

You will receive a receipt for credit card charges via email.

Email Address_____

I authorize Kristin O'Gara to charge my credit card above for the agreed therapy and or related services performed. I understand that my information will be saved on file for future services. You may cancel this agreement at any time with a written request.