New Directions - Credit Card Authorization

It is our policy at New Directions Psychotherapies PLLC to keep a credit card on file, as written in our informed consent, for missed appointments or cancellations that do not give 25 hours notice. We will always call to verify a missed appointment, and prior to processing the payment, confirm it with you.

I, _____, agree to comply with these terms and
(Your name)

give New Directions Psychotherapies, PLLC, permission to keep my credit card on file to charge the full session fee in the case of missed appointments or cancellations where 25 hours notice is not given.

Card Holders Name (as appears on card)_____

Credit Card Type_____

Credit Card #_____

Expiration Date_____

3 – Digit security code_____

Billing Zip code_____

Billing Address Numeric ONLY_____

Signature_____Date_____

I would like this credit card number to remain on file for New Directions Psychotherapies, PLLC to charge after our sessions together, and I give New Directions Psychotherapies, PLLC permission to do so.

Signature_____Date_____