# Credit Card Authorization Form

*This card information will **ONLY** be used in the event of Cancellation or No Show Appointments with Less than 24-Hour Notice for Grace Counseling Services*

| |
|---|
| Date: |
| Name: |
| Credit Card Type: Visa Mastercard |
| Name as shown on credit card: |
| Card number: CVV# Exp. Date: |
| Card Billing Street Address: |
| Card City, State, Zip Code: |
| Preferred Email to Receive Receipt of Payment: |
| I hereby authorize Grace Counseling Services to charge the above referenced account automatically in the event of cancellation or no show with less than 24 hour notice. I understand at that time I will receive an invoice with the said charge to my account. I agree to contact Grace Counseling Services at 724.779.7997 with any problems or questions regarding my account.<br><br>_____ _____<br>Signature of Card Holder Date Signed<br><br>*All information will be secured behind a two-lock system |