Credit Card Authorization

Please complete this form even if you will not be charging your sessions on a regular basis. Missed appointments and returned checks will automatically be charged to this credit account.

Client Name:_____
Name as it appears on the card:_____
Billing Address:_____
Card Type:_____
Card Number:_____
Expiration Date:_____
CVV2_____

*I authorize **GIFT Counseling Center for Wellness, LLC** to process my credit card for payment of services on a recurring basis for all scheduled appointments including missed appointments, late cancellations, and returned checks. I understand that the **client** is responsible for scheduling and canceling appointments. Late cancellations are appointments that are not successfully canceled at least 24 hours prior to the scheduled appointment.*

_____ _____
Signature Date

Email Address (for receipt):_____

GIFT Counseling Center for Wellness, LLC
119 Manly Street
Greenville, SC 29601