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CREDIT CARD PAYMENT AUTHORIZATION & CONSENT

I hereby authorize and direct McLain Coffin Counseling, LLC. to charge my credit card at the current fee rates for all services that are scheduled for the below named client. *Please note there is 3% service charge for credit card use.*

First Last MI

I understand that I will be responsible for full payment on all scheduled appointments, unless email or telephone notice of cancellation is received by Dr. Coffin more than 24 hours in advance of the appointment. If there is difficulty in processing payment through the specified credit card, I agree to provide payment in full through other payment means. My authorized credit card information is as follows:

Credit card type (circle one): Visa MasterCard Discover Amex

Name as it appears on card: _____

Credit card number: _____

Credit card expiration: _____ CVC (3 or 4 digit code): _____

Credit card billing address:

_____ _____ _____ _____
Address City State Zip Code

This authorization may be revoked by written notice only. Notice of revocation is effective upon receipt by McLain Coffin Counseling, LLC. Revocation of this agreement does not, in any way, revoke or invalidate credit card transactions that were initiated prior to receipt of revocation. Once completed this form may be brought to our office. Do not email credit card information over the internet.

By my signature below, I certify that I have read, understand, and agree to all aspects of this authorization.

_____ _____
Signature Date