

**Choices, Inc.
Counseling and Coaching
500 Roosevelt Road, Suite 205
Glen Ellyn, IL 60137**

Authorization to Secure Payment

I, _____ authorize Choices, Inc. to process payment on my Visa, Mastercard, or Discover card for my sessions not paid by other means.

I understand that if my card is declined, Choices may put my Visa, Mastercard, or Discover payment through on another day when funds become available.

I understand that I have given Choices my Visa, Mastercard, or Discover card for the purpose of making a payment for my sessions for the total amount if I do not pay my bill 30 days after it is received.

I further understand that if I miss a scheduled appointment/or fail to provide 24 hours notice, my credit card will be charged the full amount of the session.

I have read and understand this form. I attest that the information below is true and accurate.

Signature of Card Holder

My credit card information is as follows:

Card Holders's Name

Client's Name

Credit Card Account Number

V Code

Expiration Date

Is this a debit card? _____

Today's Date