

CREDIT CARD AUTHORIZATION
Elena Vladu, MS, LMFT
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Please complete this form even if you will not be using your credit card to pay for 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 Credit Card: _____

Your Billing Address: _____

Email Address (optional): _____

Credit Card Type:

Visa

Master Card

Discover

American Express

Other (please specify)

Credit Card Number: _____

Expiration Date: _____

CID (3-4 digit code on back): _____

Please Check One of the Two Options:

____ I authorize Elena Vladu, MS, LMFT 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 authorize Elena Vladu, MS, LMFT to process my credit card for payment of returned checks, missed appointments, late cancellations and visits for which I do not pay by cash or check.

Signature

Date