# ***Amigo Family Counseling, LLC***

**Credit Card Authorization Form**

_____ _____

Client's Name (Please Print) AFC Service Provider

_____ _____ _____

Cardholder's Name, As It Appears on The Card (Please Print) Relationship to Client Phone Number

_____ Photo ID Presented (Required)

Type of Card: _____ (Visa, MasterCard, Discover, etc.)

Card #: _____

Exp. Date: _____ Security Code: _____ Zip Code: _____

## *Charges: Please initial the following charges you authorize to be charged to the credit card on file:*

_____ Session Fees and Cancellation/No Show Charges

_____ All charges incurred at Amigo Family Counseling, LLC (AFC)

**Fee amounts such a documentation, phone consultations, and records release charges may differ from session fees. Ask the appropriate AFC Clinician/Staff Member about fees for these services*.

## *Duration: Please initial one of the options below:*

_____ Keep the credit card on file for the duration of treatment for the above named client

_____ Keep this credit card on file for the span dates of: _____

## *Credit Card Receipt: Please initial one of the following:*

_____ No receipt required _____Give receipt to client

_____Mail receipt to: _____

_____

Address City State Zip

*I authorize Amigo Family Counseling, LLC to charge the above selected fees to the credit card on file.*

*I understand that I must contact the appropriate AFC Clinician/Staff Member to make any changes to this authorization.*

_____ _____

Cardholder's Signature Date

_____ _____

AFC Staff Witness Date

355 E. Campus View Blvd, Suite #105, Columbus, OH 43235
Phone: 614-310-1234 FAX: 614-310-1237
Email: amigofamcounsel105@gmail.com
Website: amigofamilycounseling.com