Reflections Counseling

Confidential Credit Card Authorization
This form will be securely stored in your clinical file and may be updated upon request at any time.

Reflections Counseling
1309 Bendigo Blvd N
North Bend, WA 98045

I, _____, authorize Reflections Counseling Center to charge my credit card for professional services as follow:

- Charges per visit as agreed.
- $60 no show fee (for cancellations less than 24 hours in advance of your scheduled appointment).
- I understand this authorization is valid until I cancel it.

Please note: parents or guardians of children under the age of 18 must have a signed authorization on file. By signing this authorization, you are agreeing to the terms listed above.

Select Credit Card Type: Visa MasterCard AMEX Other

Card No. _____-_____-_____-_____

Exp. Date: _____/_____ Security Code: _____

Name as it appears on Card: _____

Phone No: _____ Email Address:_____

Billing Address: _____
Number/Street or PO Apt/Unit No. City State Zip

_____ _____

Client or Guardian's Printed Name Client Name (if Different)

_____ _____

Client or Guardian Signature Date