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Licensed Mental Health Counselor

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Pre-Authorized Use of Credit Card

I authorize Legacy Counseling, Coaching & Training, LLC to keep my signature on file and to charge my Visa / MasterCard as follows:

- ☐ Balance of charges not paid by insurance within 90 days, however not to exceed $_____
- ☐ Recurring charges for on-going treatment or for a payment plan in the amount of $_____ as of this date and continuing until I indicate in writing to stop.
- ☐ This visit only
- ☐ All visits this year.

I understand that this form is valid for one year unless I cancel the authorization in writing to the healthcare provider.

Patient Name:_____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Credit Card Account Number:_____

Expiration Date: ____ /____

3-Digit CCV Code: _____

Cardholder Signature: _____

Date: _____