**Cassandra Kotlarchik PLLC**

Cassandra Kotlarchik, MS, LMFT, CEDS

19125 North Creek Parkway Suite 120 Bothell, WA 98011

Phone: (425)405-2837

cassie@cassandrakotlarchikcounseling.com

CREDIT CARD AUTHORIZATION FORM

Credit card information is only stored within the client’s secure electronic record. Paper copies are destroyed.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Type (circle): Visa American Express Mastercard Discover

Name on Credit Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail or phone number for receipt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*I understand that Cassandra will send me invoices via e-mail, unless I have requested otherwise \_\_\_\_\_ (Initial)

\*I understand that if I do not reply to Cassandra Kotlarchik about payments within two weeks of receiving an invoice, my card with automatically be charged. \_\_\_\_\_\_\_\_\_\_ (Initial)

\*Please contact me for approval before charging my credit card \_\_\_\_\_\_\_\_\_ (Initial) **OR** automatically charge my credit card weekly or when my insurance has processed \_\_\_\_\_\_\_ (Initial)

Additional notes:

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Card Holder Signature Date