CREDIT CARD AUTHORIZATION RELEASE FORM

Practical Choices and Healthy Change Therapy, LLC

ALL INFORMATION WILL REMAIN CONFIDENTIAL

Name on Card: ____

Billing Address: ____

City: ____________________ **State:** ________________ **Zip Code:** ______________

Credit Card Type: ☐ VISA ☐ American Express ☐ Discover ☐ MasterCard

Credit Card Number: ______________________ **Expiration Date:** ________________

Security Code BACK of VISA or MasterCard: (3 digits): ______________________________

Security Code FRONT of American Express: (4 digits): ______________________________

I ______________________ authorize Practical Choices and Healthy Change Therapy, LLC and/or its
(Name of Card Owner)

owner [Jo Anna Johnson, MS, ALC] to charge the above credit card for:

- Intake Fee
- Individual Sessions Fee
- Cancellation without 24 Hour Notice Fee
- Copy of Records Fee

and, I guarantee payment for any purchases made with the credit card account number identified above.

____
Cardholder Name (please print)

______________________________ ________________
Signature Date signed