CREDIT CARD AUTHORIZATION

The client agrees to pay Logstrom Counseling, LLC all fees due, including fees for missed appointments or appointments canceled without 24-hours notice pursuant to the Logstrom Counseling, LLC Cancellation Policy.

Name as it appears on card: ____

Email Address: ____

Type of Card:

____ Visa ____ American Express
____ Master Card ____ Discover

Credit Card Number: ___________-_____________-______________- ______________

Expiration Date: ________/___________ CVV____ Zip Code: _____________
(MM) / (YYYY)

_______ Amount Authorized: The entire balance owing on each invoice that is not paid for
(initial) directly by check or cash.

______ I agree that Logstrom Counseling, LLC can charge all fees owed after each counseling session, unless
(initial) other payment is rendered at the time of service.

_____ I agree to pay the processing fee of 3% on *swiped* transactions OR 3.5% plus .15 for *manually entered*
(initial) transactions.

Authorized Signature: _______________________________________Date: ___________________