



CREDIT CARD AUTHORIZATION

I, _____, am authorizing Christine Kraus, Ph.D of Brain & Behavior Fitness,
(PRINT NAME)

to charge my credit card for any services rendered. I also authorize Brain & Behavior Fitness to charge my card in the event I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment at least 24 business hours in advance. Furthermore, for outstanding payments of services rendered, I authorize Brain & Behavior Fitness to charge my credit card for the full amount due. I will not dispute charges for sessions I have received, or that I have not cancelled less than 24 business hours in advance. I further authorize Brain & Behavior Fitness to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

Card Type (circle one): VISA MasterCard American Express

Card Number: _____ Expiration Date: _____ CID/CVV: _____

Name as Printed on Card: _____

Relationship to Patient: _____

Billing Address: _____
(STREET, CITY, STATE & ZIP)

Signature: (client or financially responsible party) _____ Date: _____

NOTE: This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 24 business hours in advance, or participation in treatment (e.g., appointment or phone session) without payment rendered.