ANGELA AIELLO LMFT PH.D.

CREDIT CARD PRE-AUTHORIZATION and AUTHORIZATION FORM

Please complete all fields. This authorization shall remain in effect for the length of therapy. You may change your credit card on file at any time by contacting us. Payment in full is required at the time of treatment.

I understand that my card will be charged in the event that I fail to provide payment in full at the time of my session.

Credit Card Information			
Card Type:	☐ MasterCard ☐ Visa ☐ Amex		
Cardholder's Name:			
Billing Address:			
City:		State:	Zip:
Phone:	Email:		
Card Number:			
Expiration Date:	[mm/yy]		
CVV Code:			

I,_____, authorize Dr. Angela Aiello to Charge my credit card in the amount of $ 200.00 for the agreed-upon Therapy Session plus a $5.00 service processing fee. I understand that my information will be saved to file for future therapy treatments on my account. Payment in full is required at the time of treatment.

I authorize the above sum to be charged to my card in the event:

- I miss my Appointment. You will be charged the full Therapy Session fee.
- I fail to cancel or reschedule within 36 hours of any appointment. You will be charged the full Therapy Session fee.
- I Fail to provide an alternate payment in full at the time of Therapy. You will be charged the full Therapy Session fee.

Card Holder's Signature _____ Date: _____