CREDIT CARD AUTHORIZATION AGREEEMENT

Your credit card information will be stored secure, in compliance with Federal HIPAA standards. If you have any questions or concerns regarding billing/payment policies, please discuss with me.

I _________________ (First and last name of card holder) authorize Harini Sukumaran, MA, MFT to charge my credit/debit for professional services.

Please initial:

___________You will be charged a full fee for any missed sessions with less than 48 hours' notice.

Missed Session Policy:

___________If you have more than 2 cancelations during the course of therapy, we may discuss the need for continuing therapy. Should you express and wish and/or desire to continue therapy, prepayment will be required.

I have read and understand the Credit Card Authorization Agreement and authorize Harini Sukumaran, MA, MFT to charge my credit card as stated above.

CARD HOLDERS SIGNATURE: ____DATE: ______________

Card Type (circle one): VISA MASTERCARD DISCOVER AE If HRA/HAS please check__________

Number: ____ Expiration Date: ________________

Verification/Security Code (3 digit code on back of card):_______________________________________

Name as printed on the card: ____

Zip Code: _________________________

Email Address I would like my receipts sent to: ____

5440 SW Westgate Dr #210 Portland OR 87221
3000 NW Stucki Pl Suite 230 Hillsboro, Oregon 97124
Phone: 503 766 4895 Email: info@mindtreeholisticcounseling.com URL: MindTreeHolisticCounseling.com