THUNDERSTORM THERAPY

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CREDIT CARD AUTHORIZATION

By completing this form, you authorize Thunderstorm Therapy to charge the card on file for session fees, copays, and any applicable late cancellation or no-show fees in accordance with the practice cancellation policy.

CLIENT INFORMATION

Client Name ______________________________

Date of Birth ______________________________ Phone ______________________________

CARD INFORMATION

Note: For your security, card details are stored through a PCI-compliant payment processor and are not retained in paper form by this practice.

■ Visa ■ Mastercard ■ American Express ■ Discover ■ HSA/FSA

Cardholder Name (as it appears on card) ______________________________

Billing Address (if different from above) ______________________________

AUTHORIZATION

I authorize Thunderstorm Therapy / Joseph Middleton, LPC-Associate to charge my credit or debit card for services rendered. I understand that:

- Session fees are due at the time of service.
- Late cancellations (less than 24 hours notice) and no-shows may be charged the full session fee.
- I will be notified before any charges outside the standard session fee are processed.
- I may update or remove my card on file at any time by contacting the practice directly.

Printed Name ______________________________

Cardholder Signature ______________________________ Date ______________________________