

**Enlightened Journeys, LLC
Dr. Toyah T. Wilson, Psy.D.**

CREDIT CARD AUTHORIZATION AGREEMENT

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

In case of late cancellations and/or no shows for scheduled sessions, or if a check is returned unpaid, you will be charged the full session fee. An additional \$25 will be assessed for returned checks. In addition, if there is a balance remaining on your account that is not payable by insurance benefits, you are then responsible for payment of this balance.

I, _____, am authorizing Dr. Toyah T. Wilson, Psy.D. to use my credit card information to charge in the event that I do not notify her of my inability to attend scheduled therapy appointments and/or do not cancel my appointments at least 48 hours in advance, or if a check is returned for any reason, or if I carry an account balance not covered by insurance as agreed to in the signed Client Billing Policies/Late Charges Form.

I will not dispute charges ("charge back") for sessions I have received or for appointments I have missed according to the above policy.

Card Type (circle one): Visa, MasterCard

Card # _____ Expiration Date: _____

Name as Printed on
Card: _____

Verification/Security Code (3-digit code on back of card by signature
line): _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Print Name: _____

By signing below I am authorizing Dr. Toyah T. Wilson, Psy.D. to charge for missed scheduled appointments and/or outstanding account balances.

Signature: _____ Date: _____