CREDIT CARD AUTHORIZATION

By signing this form, I am giving Kristina Schasker, MA, MFT permission to charge my credit card the amount we have agreed to upon entering treatment as stated below. I am giving Kristina Schasker, M.A., MFT permission to charge my credit card each time we have a session and/or if I cancel or miss my scheduled appointment WITHOUT giving 24-hour notice. By signing this form, I am stating that it supersedes having to visit Pay Pal and authorize payment each time I have an appointment.

If I have any concerns about a charge I will direct them to Kristina Schasker, M.A., MFT to be resolved. I have a choice to pay by cash or check as well but if I decide to use a credit card, this policy will be in effect.

_______________________________________ _______ _______ ________

Credit Card Number Exp. Security Fee

____

Name on Card

____

Billing Address

____

Phone Number Email Address

____

Authorization Signature Date