LOTUS
COUNSELING CENTER

CREDIT CARD PAYMENT AUTHORIZATION FORM

Please indicate the form of payment you wish to use for any services rendered through Lotus Counseling Center. This information will be securely stored in your clinical file and may be updated upon request at any time.

Client Information:

Client Name: _____ Date of Birth: _____ /_____ /_____

Address: _____

City: _____ State: _____ Zip: _____

Mobile Number: _____ Email: _____

Credit/Debit Card Information:

Card Type: ☐ VISA ☐ MASTERCARD

Card Number: _____-_____-_____-_____ Expiration Date: _____ / _____

Card Holder Information:

Please indicate the name and address associated with the credit or debit card you wish to use.

Card Holder: _____ Date of Birth: _____ /_____ /_____

Card Holder's Address: _____

City: _____ State: _____ Zip: _____

Mobile Number: _____ Email: _____

_____ _____

Signature of Client / Card Holder **Date**

For admin use only
Therapist:
Fee:
AFFU:
Initial:

Please return this form to the front office.

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