Credit Card Authorization

Fillable · Complete and email to Robert

Type directly into each field. Click 'Submit by Email' when complete. (503) 383-9144 · robert@branching-streams.com

CLIENT INFORMATION

Client Full Name

Date of Birth

Phone

Email

PAYMENT INFORMATION

Cardholder Name (exactly as on card)

Card Number

Expiration (MM/YY) / CVV

Card Type

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

Billing Address / Billing ZIP

AUTHORIZATION SCOPE — check all that apply

☐ Session co-pay or deductible (insurance clients)

☐ Full session fee — $180 (self-pay clients)

☐ Late cancellation / no-show fee (less than 24 hours notice)

☐ Outstanding balance (with prior notice)

TERMS

I authorize Branching Streams Psychotherapy, LLC to charge the card above for the selected purposes. I understand I will receive a receipt by email. I may update or revoke this authorization in writing with 5 business days' notice, except for amounts already due.

Cardholder Signature (type name)

Date

Submit by Email to Robert

Clicking opens your email app — attach completed PDF and send to robert@branching-streams.com