



Specialists in Mental Health

Authorization for Automatic Debit/Credit Card Payments

Floyd Godfrey, MA, LPC Leslie Whiting, M.Ed., LPC John Hinson, MA, LPC Wesley Weeks, MA, LPC Kim Buck, MA, LAC
Dan Oakes M.Ed., LPC Marilyn Tenney, LPC Wayne Spence , Bio/ Nero Feedback

Client Name: _____

Parent/Guardian Name: _____

Date: _____

By my signature below, I authorize FAMILY STRATEGIES & COACHING, LLC (Floyd Godfrey, LPC) to debit/charge the account number I have specified below for the contracted amount. I understand that my account will be charged the week of the appointment. Missed appointment fees will also be assessed to my account. One week's written notice will be needed to cancel this authorization.

A credit card/debit receipt will be issued after each session as documentation for your records. A signature will be required on these receipts.

DEBIT/CREDIT CARD AUTHORIZATION

Please circle the card type. VISA/ MasterCard/ Discover Card/ American Express Card

Name as it appears on the card: _____

Charge #: _____

Exp. Date: _____

CVV2 # on the back of the card _____

First 4 numbers of your billing address _____

Zip number _____

Signature _____

Home Phone: _____ Work Phone: _____