Beach Psychotherapy
1767 Grand Ave. Suite 4, San Diego, CA 92109

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

I authorize Beach Psychotherapy to charge my credit/debit card for professional services as follows:

Please initial:

_____Recurring charges for services in the amount of $_____per visit.

_____I understand and agree that my card will be charged full fee for cancellations with less than 24 hours notice and for appointments I miss without notice.

_____I understand this form is valid for one year unless I cancel the authorization in writing. I will not dispute charge ("charge back") for sessions I have received or appointments I missed according to the above policy.

I,____, am authorizing Beach Psychotherapy the use of my credit card in the event that I do not notify my therapist of my inability to attend a scheduled therapy appointment and/or do not cancel my appointment at least 24 hours in advance as agreed to in the informed consent form I signed.

Card Type (circle one): Visa Mastercard

Card #_____________________________________Expiration Date: ___________________

Name as Printed on Card:____

Verification/Security Code: (3 digit code on back by signature)___________________

Billing Address for Card:____

(Street, City, State and Zip)

Signature:____Date:______________