



TENDER HELP FOR TOUGH PROBLEMS

Credit Card/Debit Payment Agreement

DISCLAIMER:

CREDIT AND DEBT CHARGES ARE NOT PROCESSED ON THE SAME DAY AS YOUR SESSION. IN SOME CASES, THE CHARGES MAY BE PROCESSED ONLY ONE OR TWO TIMES PER MONTH. IF THIS IS A CONCERN OR PROBLEM, PLEASE LET YOUR THERAPIST KNOW.

Client Name: _____ (PLEASE PRINT)

Therapist Name: _____

I authorize the administrative staff of Turning Point Counseling to charge the listed credit card for future services provided by the therapist named above starting _____ (date). Authorization is good until _____ (date).

All credit card receipts will be filed in the Turning Point counseling corporate office. If you would like a copy of the credit card receipts, please contact the corporate office at (800) 998-6329.

Credit Card Information: (All of the fields are required.)

Type: Visa Master Card American Express

Name as is appears on Card: _____

Card Number: _____ - _____ - _____ - _____

Security Code: _____ (3 digit code on the back for Visa/MC, 4 digit code on the front for Amex)

Expiration Date: _____/_____

Street Number: _____ (Billing address that is linked to the credit card above)

Zip Code: _____

Client Signature: _____ Date: _____

Cardholder Signature: _____ Date: _____
(If different from client)

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