Credit Card Authorisation

I collect your credit card information to keep on file for billing purposes. The information you provide will be protected as confidential.

Cancellations must be received 24 hours prior to the scheduled appointment. If 24 hours notice is not given, you will be charged the full amount, plus the credit card fees for the missed session. By completing this form, you provide consent for me to charge your card for missed appointments.

Name on Card: ____

Billing Address: ____

____

Credit Card Type: _____ Visa _____ Mastercard

Credit Card Number: ____

Expiration Date: ____

Card Identification Number: ______ (last 3 digits located on the back of the credit card)

Hourly Rate : $ ________________ (CAD) (Put "**As Invoiced**" if amount will vary)

I authorize Weskin Psychological Services to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement. Cancellation of this agreement must be made in writing with 14 days notice.

Cardholder – Please Sign and Date

Signature: ____

Date: ____

Print Name: ____

This authorisation remains valid for 12 months.