Dan Hooley MA LCPC || 9700 W State Street, Star, ID 83669

CREDIT CARD AUTHORIZATION FORM

I ________________________________, date of birth_________________, do hereby authorize Dan Hooley MA LCPC of Dan Hooley Therapy to use my credit card as payment for services rendered. I realize that this card may be used in the event that I do not give 24-hour cancelation notice prior to the appointment time. Also, I realize that there is a $5 cash discount for payments made by check/cash and that by using the card I will not receive the discount. There will be a $25 charge for any bounced/bad checks received. I understand that 24 hour cancelations will only be accepted via text or call, **not from email**. I understand that I may choose to use this credit card for regularly billed sessions and/or other services, but that it will also be charged in the event of failure to provide 24-hour notice of missing a session.

Card Number___________________________________Name on Card______________________________

Expiration Date__________________CSC Number___________Address___________________________

City/State/Zip Code____Phone________________________

Email____

I agree to the above information as being accurate and complete to the best of my knowledge, I also agree to all of the rights and privileges that are associated with this credit card.

Print______________________Cardholder's Signature______________________________Date_____________