# CREDIT CARD "Signature on File" AUTHORIZATION FORM

Audrey A. Simmons, MA, LMHC located at 738 8th Street, Clermont, FL 34711 is authorized to maintain credit card payment information in her secure and confidential files. This form is being provided for you to supply Audrey A. Simmons, MA, LMHC with this information for an automatic payment option. Your signature authorizes me to review this information and deduct my fees for professional services from the credit card(s) below.

Please Print:

Client Name: _____

Address: _____

City, State, Zip Code: _____

Phone, E-Mail: _____

Primary Credit Card:

Cardholder Name (as imprinted on the credit card):_____

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date – Security Code _____ - _____

Type of Card: __ MasterCard__VISA___American Express___Other_____

Secondary Credit Card:

Cardholder Name (as imprinted on the credit card):_____

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date – Security Code _____ - _____

Type of Card:

By signing this form, I give permission to Audrey A. Simmons, MA, LMHC of 738 8th St, Clermont, FL 34711 to charge my above credit card(s) for fees related to my professional services. If I am using my company's credit card, I am signing as an authorized user. My signature below confirms my knowledge and acceptance of fees, terms, and policies of Audrey A. Simmons, MA, LMHC at 738 8th St, Clermont, FL. I also understand and agree to accept responsibility for payment of any and all services goods rendered should my credit card(s) deny all or part of this charge as it will then become solely my responsibility.

Authorized Signature: _____

Print Name: _____

Date: _____