INSIGHTS COLLABORATIVE THERAPY GROUP
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CREDIT/DEBIT CARD AUTHORIZATION

I agree that Insights Collaborative Therapy Group may charge, and I agree to pay, the following credit/debit card for all fees for services it renders to _____ (name), plus an administrative charge of 4% for each credit/debit card transaction. I agree to pay these charges in accordance with the issuing bank cardholder agreement.

Card Type: _____ Visa _____ MasterCard _____ Discover _____ AmEx

Name on Card: _____

Card Number: _____

Billing Address (including zip code): _____

3- or 4- Digit Security Code: _____

Expiration: _____

_____

Client signature Date