# Dr. Janice Avalone, Psy.D., LMFT

Licensed Marriage & Family Therapist # MFC 106305

30900 Rancho Viejo Rd. Suite 140, San Juan Capistrano, CA 92675

*949-370-7671 e-mail: drjaniceavalone@gmail.com*

www.drjaniceavalone.com


**Credit Card Payment Authorization**

I hereby authorize and direct Dr. Janice Avalone to charge my credit card at the then current fee rate for all services that are scheduled for the below named client.

Name of Client: _____

First Last MI

I understand that I will be responsible for full payment on all scheduled appointments, unless notice of cancellation is received by Dr. Janice Avalone more than 48 hours in advance of the appointment. If there is difficulty in processing payment through the specified credit card, I agree to provide payment-in-full through other payment means. My authorized credit card information is as follows:

Credit Card Type (**Bold** one): Visa MasterCard Discover

Name as it appears on card: _____

Credit card number: _____

Credit card Expiration: _____ CVC (3 or 4-digit code): _____

Credit card billing address: _____

Address City State Zip

This authorization shall remain in effect for two full years from the date of signing. This authorization may be revoked by written notice only. Notice of revocation is effective upon receipt by Dr. Janice Avalone. Revocation of this agreement does not, in any way, revoke or invalidate credit card transactions that were initiated prior to receipt of revocation. Once completed, this form may be brought to Dr. Avalone's main office. Please do not email credit card information over the internet.

If any provisions of this authorization are held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provisions.

**By my signature below, I certify that I have read, understand, and agree to all aspects of this authorizations.**

_____ _____

**Signature** **Date**

_____

**Printed Name**