

Credit Card Payment Information

I authorize Tori Clear Thompson, LCSW of Clear Counseling Choice, LLC to keep my signature on file and to charge this credit card account for, as per my signed Consent Form, any missed appointments, late-cancellations (less than 24-hour notice), or scheduled TeleMental Health sessions. I understand that all charges will appear under the name Clear Counseling Choice, LLC. I further understand that Tori Clear Thompson will notify me via phone call or email once the credit card has been billed for the agreed upon hourly rate of \$150 plus an additional \$5 credit card convenience fee.

I understand that this authorization remains valid unless I cancel the authorization through written notice. I also agree to contact Tori Clear Thompson, LCSW of Clear Counseling Choice, LLC if there are changes to my credit card account information.

Please complete the information below:

_____ Master Card _____ Visa _____ American Express _____ Discover

Cardholder Name

Cardholder Billing Address

City

State

Zip Code

Phone Number

E-Mail Address

Credit Card Account Number

Expiration Date

Security Code

Cardholder Signature

Date



Tori Clear Thompson LCSW
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