CROSSROADS Behavioral Health

10 North Main Street ● West Hartford CT 06107 ● Tel: 860-233-8111 ● Fax: 860-236-2016

MASTERCARD/VISA AUTHORIZATION AGREEMENT

MASTERCARD/VISA (circle one): #_____

Expiration Date: _____

Last 3 Digits of Security Code (on back of card):_____

Billing Address: _____
Street

_____
City, State Zip code

I, _____ authorize Crossroads Behavioral Health to submit charges to my ____MASTERCARD or ____VISA for my ***psychotherapy*** sessions. I understand that "No Show" appointments or cancellations made less than 24 hours in advance of my appointment will also be charged to my credit card, and that cancellations must be made by telephone only.

_____ _____
(Date) (Client Signature)