CROSSROADS Behavioral Health

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

MASTERCARD/VISA AUTHORIZATION AGREEMENT

I, _____ authorize Crossroads Behavioral Health to submit charges to my ____MASTERCARD / ____VISA #_____-_____-_____-_____ Expiration Date: __/__/__, Security code (last 3 digits on back of card) _____, for ***The Highlands Ability Battery and/or coaching 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)