CROSSROADS Behavioral Health, LLC

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MASTERCARD/VISA AUTHORIZATION AGREEMENT
For Coaching Meetings

MASTERCARD/VISA: #_____

Expiration Date: _____

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

Billing Address: _____
Street

_____
City, State Zip Code

I, _____ authorize Crossroads Behavioral Health, LLC to submit charges to my ____MASTERCARD or ____VISA for my **coaching** meetings. 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. Cancellations may be made by telephone or email communication.

_____ _____
Date Client Signature