

**Matt Wagner, LPC, Inc.**  
**Matthew S. Wagner, LPC #9583, CAADC #C0212**  
**545 N. McDonough St., Suite 212, Decatur, GA 30030, 770.766.8128**

**CREDIT CARD AUTHORIZATION FORM**

Complete this authorization form if you wish to pay by credit card for services with Matt Wagner, LPC, Inc. All information will remain confidential. Please print clearly.

Cardholder Name:

\_\_\_\_\_

Billing Address: \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code:

\_\_\_\_\_

Credit Card Type: \_\_\_\_\_ Visa \_\_\_\_\_ Mastercard \_\_\_\_\_ AmEx \_\_\_\_\_ Other:

\_\_\_\_\_

Credit Card Number:

\_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVV/I.D. Number (3 or 4 digits on back):

\_\_\_\_\_

Amount to Charge Per Session: \$ \_\_\_\_\_ (USD) This amount may change in the future if agreed by therapist and client. **NOTE: THERE IS AN ADDITIONAL \$2.50 SERVICE FEE FOR ALL CREDIT CARD CHARGES**

Agreement:

I authorize **Matt Wagner, LPC, Inc.** to charge the agreed amount listed above to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

I understand and agree that my card will be charged for a missed appointment if I fail to give at least 24 hours notice of cancellation.

I agree to update Matt Wagner, LPC, Inc. if my card becomes inactive, is replaced, or expires.

Cardholder - Print Name, Sign and Date Below:

Signed:

\_\_\_\_\_

Dated:

\_\_\_\_\_

Printed Name:

\_\_\_\_\_

How would you like to receive receipts?

Email: (enter email address)

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Text: (enter preferred phone number)

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