**Clarke Counseling Center, LLC**

**Sherry Clarke, M. A., LCMFT**

**Licensed Clinical Marriage and Family Therapist**

**301-956-0900**

**Credit Card Pre-Authorization**

I authorize Clarke Counseling Center, LLC to keep my signature on file and to charge my Visa or MasterCard account for recurring charges of $\_\_\_\_\_\_ per \_\_\_\_\_\_\_\_\_\_\_minute psychotherapy or coaching session.

I understand this form is valid for two years unless I cancel the authorization in writing. I promise not to dispute charges (“charge back”) for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize Clarke Counseling Center, LLC to disclose information about my attendance/cancellation to my credit card issuer, if I dispute a charge.

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Client (s) Name

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Cardholder Name

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