Mental Fitness Lifestyle, Inc.

22231 Mulholland Hwy, Suite 210
Calabasas, California 91302
(818) 224-4486

AUTHORIZATION TO KEEP ON FILE AND CHARGE CREDIT CARD

I hereby authorize Mental Fitness Lifestyle, Inc. and its employees to process the credit card I have provided to keep on file for services both rendered and forthcoming in accordance with the Consent and Policies Form I have been provided, reviewed and signed. Services may include, but are not limited to: therapy sessions for myself/my child, group therapy sessions, workshops, phone calls, records review, report/letter preparation, professional consultations, and e-mail correspondences. This permission includes charges for No Show and Late Cancellation appointments as per the signed Consent and Policies Form. In accordance with the cancellation policy detailed in the Consent and Policies Form, the card on file may be charged at any time twenty-four (24) hours prior to any scheduled therapy sessions, and anytime thereafter. For any services outside of scheduled therapy sessions, the credit card on file may be charged at any time once the service has been confirmed and/or taken place per office policies.

Client Name: _____

Parent(s) Name(s) if client is a minor: _____

Name on Credit Card: _____

Address on credit card account: _____

Zip code on credit card account: _____ Type of credit card: _____

CARD NUMBER: _____-_____-_____-_____ **CARD EXPRIATION DATE**: ____/____

CARD IMPRINT (place card under paper and rub over it gently with a pencil or crayon):

In signing this form I am providing my agreement with the above stated polices and assuring all of my questions regarding same have been addressed to my satisfaction. This authorization shall remain in effect throughout the duration of my/my child's clinical work with the therapists of Mental Fitness Lifestyle, Inc., and I agree to update card information as needed to assure the credit card on file is active, able to be processed, and has not become expired or compromised. This form will be disposed of (shredded) at the conclusion of treatment and the final payment of any outstanding or final balance due per the Consent and Policies Form.

Cardholder Signature: _____ Date: _____