Restore Life Counseling, LLC

Credit Card Guarantee

I agree that if I fail to confirm my scheduled counseling appointment 24 hours in advance, and I fail to make additional arrangements with my therapist or reschedule the appointment during that 24-hour time-period, I will pay the full fee for the missed session.

Credit Card Type: ___Visa ___MasterCard ___Amex ___Discover

Cardholder Name: _____

Billing Address: _____

_____

_____

Card #:_____ Exp Date:_____

Three digit CID number:_____(located on the back of card)

I agree to the above terms and authorize Restore Life Counseling LLC to charge the payment of the missed appointment.

_____

Signature Date