Credit card information to be kept on file with Suda Centers, Inc.

Client name:_____

Credit card number:_____

Expiration date:_____

CVV #:_____

Billing ZIP:_____

I hereby authorize Suda Centers, Inc. to use the credit card information provided here in order to charge for missed psychotherapy sessions that are not canceled at least 24 hours in advance, as well as any recurring psychotherapy appointments at Suda Centers Inc. I understand that insurers do not reimburse for these missed sessions and I am personally responsible for payment.

Name (print):_____

Signature:_____

Date:_____