

## CREDIT CARD AUTHORIZATION

I, (print name) \_\_\_\_\_ authorize Bluegrass Nutrition Counseling to charge my credit card for outstanding balances OR for payment of services rendered in the event that I fail to show for a scheduled appointment without giving 24 hours advance notice. I will not dispute any balance due for sessions I have received or for those I have failed to provide 24 hours advance notice of cancellation.

I further authorize Bluegrass Nutrition Counseling to disclose information about my attendance/cancellation to my credit card company if I dispute a charge. Please note your card will not be charged unless these conditions apply.

**Card type (circle one):**      Visa                  MasterCard                  Discover                  AMEX

**Credit or Debit Card Info:**

Card# \_\_\_\_\_ Exp.Date: \_\_\_\_\_ CVV: \_\_\_\_\_

Name (as printed on card): \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(client or financially responsible party)