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.

Cardtype(circleone): Visa MasterCard Discover AMEX

Is this card a Health Spending Account? Yes No

If yes, then please complete both fields below as missed appointments CANNOT be charged to your Health Spending Account.

Credit or Debit Card Info:

Card #_____Exp. Date:_____CVV: _____

Name (as printed on card): _____

Relationship toclient: _____

Billing Zip Code:_____

Signature:_____Date: _____
(client or financially responsibleparty)

Health Savings Account Info:

Card #_____Exp. Date:_____CVV: _____

Name (as printed on card): _____

Relationship toclient: _____

Billing Zip Code:_____

Signature:_____Date: _____
(client or financially responsibleparty)

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