CROSSROADS COUNSELLING
EVERYONE MATTERS

Credit Card Payment

Fee Payment Details	
❑ One-Time $________	❑ Recurring $________
Client Name: ___________________________	Therapist Name: _________________________

Additional Information

Personal Information of Credit Card Holder				
First Name:		Last Name:		
Street Address:		City:		
Province:		Postal Code:		
Main Phone:		Email:		

Card Type	Card Details
❑ Visa ❑ Mastercard	Cardholder Name : ______________________________
	Card Number: __________________________________
	Expiration Date (mm/yy): ____ /____
	CVV Code (3 digits on back of card): ______

Authorization
I authorize Crossroads Counselling Centre Society to charge my credit card with the above noted session fees. I understand & agree that if this authorization is for more than a one-time payment, it will remain in effect until cancelled and that my information will be kept on file.
Cardholder Signature: ____________________________________ Date: __________________________