



Fee Payment Details	
<input type="checkbox"/> One-Time \$ _____ <input type="checkbox"/> 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
<input type="checkbox"/> Visa <input type="checkbox"/> 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: _____