**Diversified Health & Wellness Center**
**11042 Manchester Road**
**Kirkwood, MO 63122**

# Credit Card Authorization Form

**All information will remain confidential**

**Card Holder Name:**_____ **Address:**_____

**Client Name** **(if different than cardholder):**_____ _____

_____ _____

**Phone:**_____ **Zip:**_____

**Card Number:**_____ **Expiration:**_____ **CVV:**_____

***Session Co-Pay** _____
(initial)

***Deductible** _____
(initial)

***Session Co-Insurance** _____
**(initial)**

***Other misc. charges** **(agreed upon at time of charge books, materials etc…)** _____
**(initial)**

Credit Card information: I authorize Samira Saleh /Diversified Health & Wellness Center, LLC to charge the agreed amounts listed above to my credit/debit card provided herein. I agree that I will pay for the services rendered in accordance with the issuing bank cardholder agreement. This agreement will be good for one year, the end of services or the expiration of the stated card or other agreed upon date: _____
(attach copy of credit/debit card)

*Cardholder* print name, sign, and date below:

**Printed:**_____

**Signed:**_____

**Dated:**_____

*Counselor* print name, sign, and date below:

**Printed:**_____

**Signed:**_____

**Dated:**_____