



98-1238 Kaahumanu St. Suite 203
Pearl City, HI 96782
Tel (808) 226-9442
Fax (808) 210-6100
edwinareyes@gmail.com
edwinareyes.com

NAME OF PATIENT: _____

CARDHOLDER INFORMATION

Name: _____

Billing Street Address: _____

City: _____ State: _____ Postal Code: _____

Email: _____ Direct Telephone: (____) _____ - _____

PAYMENT INFORMATION:

I authorize Life Counseling Inc. a one-time charge against my credit card ending in _____ for the following amount: \$ _____

I authorize Life Counseling Inc. a recurring charge against my credit card ending in _____ for the following amount: \$ _____ for each visit (Please note that this amount will change based on your insurance coverage as well as the type of session held at the time of service. Your credit card will be charged accordingly.)

CREDIT CARD INFORMATION

Credit Card Type: MasterCard Visa American Express Discover Card

Number: _____

Expiration Month: _____ Expiration Year: _____

Cardholder Signature X _____ Date: _____

Security Code: _____ (found on the front of AMEX and on the back of VISA and MC)

I hereby authorize Life Counseling Inc. to charge my office visit to the above credit card for the account listed above. I certify that I am the authorized cardholder of record and that I have full authority to make purchases on behalf of the account listed above. I understand that my insurance coverage might change as well as the session held in which that will reflect a different amount on my recurring charge.

SIGNATURE OF CARDHOLDER: _____ **DATE:** _____