



*Full Circle Therapy*  
*2500 McAndrews Road #230*  
*Burnsville, MN 55379*  
*952-892-8404*

This authorization form will be securely stored in your file and remains valid for one year unless you cancel it in writing. You may update or revoke this agreement at any time by providing a written request.

I authorize Joan Lompart, LMFT to keep my credit/debit card information and signature on file and to charge my card for the following reasons:

Please initial:

- \_\_\_\_\_ **Appointments attended.** For co-payment or when this is my intended payment method at the time of service.
- \_\_\_\_\_ **Missed appointments.** I understand and agree that my card will be charged the full session amount for cancellations without notice by 9 a.m. the prior business day and for appointments I fail/miss without proper notice.
- \_\_\_\_\_ **Charge backs.** I will not dispute charges for sessions I have received or appointments I missed according to the above policy. An additional \$30 is assessed if valid charges are disputed.
- \_\_\_\_\_ **Insufficient funds/returned checks.** A \$30 fee is assessed.

Card Type:     Visa     MasterCard     Discover

Number \_\_\_\_\_

Expiration \_\_\_\_\_ Security Code \_\_\_\_\_

Name (as printed on card) \_\_\_\_\_

Billing Address \_\_\_\_\_

Zip \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_