VALENCIA RELATIONSHIP INSTITUTE
28494 Westinghouse Place, Ste. 213
Valencia, CA 91355

PRE-AUTHORIZED HEALTH CARE FORM

I authorize Valencia Relationship Institute to keep my signature on file and to charge my credit card account for:

1. Balance of charges not paid by me and not to exceed $_____ for:
This visit only_____ All visits_____

2. Recurring charges (on-going treatments) of $_____ every
_____ from _____ to_____. (fee)
(frequency) (date) (date)

**I understand I may revoke this agreement at any time by providing a request in writing.

Client´s Name_____

Cardholder´s Name_____

Cardholder´s Address_____

City_____State_____Zip_____

VISA___ MASTERCARD___

Account number_____Expiration_____
Security Code on the back of the card_____

Signature_____Date_____

Therapist agrees to only charge for services rendered or for cancellation fee if appointment is not cancelled within 48 hours.

_____ _____
Therapist's Signature Date