Doreen A. Zaborac & Associates, Inc.

Zaborac Counseling Group

17255 Oak Park Avenue
Tinley Park, IL 60477
708.633.4533

Credit Card Authorization

CARD HOLDER FIRST NAME: _____ (As it appears on credit card) M.I._____

CARD HOLDER LAST NAME: _____ (As it appears on credit card)

CREDIT CARD TYPE: _____ CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____ CVV: _____ ZIP CODE: _____

I, _____, hereby authorize DOREEN A. ZABORAC & ASSOCIATES, INC. to utilize the
(CARDHOLDER NAME)
credit card listed above for services rendered by clinicians at DOREEN A. ZABORAC & ASSOCIATES, INC. and for services

provided to _____.
(PATIENT/CLIENT NAME)

I understand that payment is due at the time of service and that my credit card will be utilized for unpaid balances 14 days after the client/responsible party has been notified of an existing balance. Clients/responsible parties are welcome to utilize alternate payment methods on the date of service or prior to the 14 day payment window.

AND

I attest that I am legally authorized to provide and utilize the credit card listed above for the payment of services rendered at DOREEN A. ZABORAC & ASSOCIATES, INC.

CLIENT NAME: _____ DATE: _____
(PRINT)

CLIENT SIGNATURE: _____

CARD HOLDER SIGNATURE: _____ DATE: _____