SoulCare Counseling

Credit Card Guarantee

Client name:

Cardholder's name:

Card Billing Address:

Billing zip code:

Card type: ☐ Amex ☐ MC ☐ Visa ☐ Discover

Card Number: Exp. Date:

Security code:

By typing my signature below, I hereby authorize Remark Enterprises dba SoulCare Counseling, to charge the above card for any outstanding balance incurred by missed appointments, late cancellations, or unplanned extended session times.

Typed Signature Date