Possible Counseling Services

Credit Card Authorization Form

Please note: by signing below, you agree this form will be securely stored in your HIPAA compliant clinical file. I authorize Possible Counseling Services to keep my signature and credit card information on file to charge therapy session fees (if not paying by cash), any appointments that are not cancelled within 24 hours of the scheduled appointment time:

____

(Client's Name: Please Print)

I understand that this authorization is valid until canceled in writing. Additionally, I agree that the card listed below may be charged by Possible Counseling Services in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services. **Initial ______**

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Possible Counseling Services for assistance and/or disclosure. **Initial**______

Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by possible counseling services. **Initial _____**

Cardholder Name [as appear in the card]:____________________________________

Relationship to client: ____________________________

Card Type (circle one): ***Visa * MasterCard *** American Express *** Discover**

Acct. Number: _________________________ Exp. Date: ____________
(Month/Year)

CVV number: (3-digit number in reverse italics on the back of the credit card) _____________

Billing Address: ____

I understand that my therapy sessions will be charged via this form:

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Signature: __________________________________ Date:_____________

possiblecounseling@gmail.com