FASH COUNSELING

# Fash Counseling Credit Card Authorization

Date: _____

I, _____ authorize payment to be processed on my credit card for services rendered for _____ (client).

_____ (initials)

I understand that I have given Fash Counseling my credit card for the purpose of charging a co-pay and/or coinsurance and deductible.

_____ (initials)

I understand that if my card is declined, Fash Counseling may put credit card payment through on another day when funds become available.

_____ (initials)

I understand that Fash Counseling may charge my credit card the full amount due (minus insurance pending) if I do not make a payment within 30 days of the statement date. Also, I understand that because I have not made payment that Fash Counseling is not required to contact me prior to the charge and that they are not responsible for any fees that may occur as a result of limited funds.

_____ (initials)

I further understand that if I miss a scheduled appointment/or fail to provide 24 hours' notice, my credit card will be charged full amount of the session.

_____ (initials)

I understand that I am responsible for keeping my credit card account information up to date and provide immediate notification of any change to my credit card information.

_____ (initials)

I have read and understand this form. I attest that the information below is true and correct.

_____ (initials)

_____
Signature of Card Holder

My credit card information:

_____
Cardholder's Name

_____ _____ _____ _____
Cardholder's Street Address City State Zip

_____ _____ _____
Credit Card Account Number V Code Expiration Date

** This form is valid through the length of treatment*