Family Therapeutics

Credit Card Authorization Form

Please complete the following information:

I, the undersigned individual, authorize Family Therapeutics to charge my credit card in the event that I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify Family Therapeutics staff of my inability to attend a scheduled appointment at least 48 business hours in advance, as agreed to in the Treatment Consent Form. Furthermore, for outstanding payments of services rendered, I authorize Family Therapeutics staff to charge my credit card for the full amount due. I will not dispute charges for sessions I have received or that I have not canceled less than 48 business hours in advance. I further authorize Family Therapeutics to disclose information about my attendance and/or cancellation to my credit card company should there be a charge dispute.

Card Type (please check): ☐ Visa ☐ MasterCard

Card #: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Exp Date: ☐☐ / ☐☐

Name as Printed on Card:

Verification/Security Code: ☐☐☐

(3-digit code on back by signature line)

Billing Address:

(Street)

(City) (State) (Zip)

Signature: **X**____ Date: ____________

(patient or financially responsible party)

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will only be charged with your approval unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 48 business hours in advance, or participation in treatment without payment rendered.

USING YOUR CARD FOR REGULAR BILLING OF APPOINTMENTS:
Please sign and date here if you would like us to bill your regularly scheduled sessions to the above card.

Signature: **X**____ Date: ____________

(patient or financially responsible party)