



Authorization for Credit/Debit Card On-File

Envision Counseling Clinic requests that you provide your credit card information below. If you choose to pay by credit card your credit card will be charged the full fee of your sessions after each session on the day the session occurs. If you choose to pay by cash or check, your credit card will only be charged if your account is past due and/or for any additional fees you incur such as late cancellation or no-shows fees.

I authorize Envision Counseling Clinic to charge my credit card \$_____ after each session and for any and all additional fees I incur.

I do not authorize Envision Counseling Clinic to charge my credit card after each session but only for additional fees I incur as set forth in ECC's disclosure statement and policies. I will be notified of the type of additional fees I incur.

CARD INFORMATION

VISA DISCOVER AMERICAN EXPRESS MASTERCARD

Card Number: _____ Exp. Date _____ V Code _____
(3 digit code on back of card)

Card Holder Name _____ Phone Number _____

Billing Address _____
Street City State Zip

- Your credit card information will be kept in a secure location and will be kept confidential. We *will not share* your credit card information with anyone.
- We will charge your credit card upon request for *services to yourself or to anyone you authorize.*
- We will charge your credit card a Missed Appointment Fee of \$50 *for appointments not cancelled with 24 hours notice by yourself or to anyone you authorize. We will notify you if a Missed Appointment fee is charged to your card.*
- This credit card authorization form will remain in effect and on file at Envision Counseling Clinic unless revoked in writing or until the therapeutic relationship is terminated, at which time, authorization to charge your credit card will be revoked, unless an outstanding balance remains on your account after termination.
- **Credit card transactions may appear as coming from Envision Counseling Clinic, your therapists' name, TheraNest, Therapy_Svc, or Braintree.**

(Please continue on the reverse side)

RECEIPTS (check one) Give or send me a paper copy of the receipts
 EMAIL me receipts* at my e-mail or _____
 Do NOT send me receipts

CARDHOLDER AUTHORIZATION

In addition to my services, I authorize Envision Counseling Clinic to charge my card for the following patients:

	<u>Client (last, first, MI)</u>	<u>Relationship to Client</u>	<u>Client ID (Completed by staff)</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

By signing this authorization form, you agree to notify Envision Counseling Clinic of any changes to your credit card information such as a new expiration date or when your credit card has been cancelled or revoked.

I _____, hereby authorize Envision Counseling Clinic to charge the above bank credit card number for payment of the counseling fees I or my minor child/ren incur; which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above. I agree to notify Envision Counseling Clinic of any changes to my credit card information including a new expiration date or when my credit card has been cancelled or revoked.

Signature of cardholder _____ **Date** _____

*Receipts will be emailed directly from TheraNest