Credit/Debit Authorization Form

Credit card information is to remain on file for charges accrued by late cancellation or missed sessions, services rendered during scheduled sessions in the office or phone consultations, or balance due per insurance claim statement. This form will be kept securely and me be updated at any time upon your request.

I, _____, understand the payment policies and authorize Back to Balance Counseling, LLC to charge my credit/debit card in the event:

- I do not attend a scheduled therapy appointment that I have not cancelled 24 hours in advance ($80 fee)
- I do not pay balance due from co-pay, co-insurance, or deductible as indicated by insurance carrier after 3 unanswered invoice cycles
- My check is returned for any reason and NSF fee as designated by bank is charged
- A phone consultation of 20 minutes or longer is provided

Card type: Visa MasterCard Discover American Express

Card #:_____ **Exp Date**:_____

Name as printed on card:_____

Verification/Security Code (on back):_____ **Billing Zip Code**:_____

Signature of cardholder:_____ **Date**:_____

Recurring Payment Option

By signing below, I request that my information be securely stored for regular payment and authorize Back to Balance Counseling, LLC to charge my credit/debit card on an ongoing basis for scheduled appointments.

Signature of cardholder:_____ **Date**:_____

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