



Credit Card Authorization

By signing this agreement, you authorize Healing Hearts Therapy to bill your credit card for all professional services rendered to the client that are not paid in full at the time of service, or for situations listed below. There will be a charge of \$200 per 50-minute session or \$70 per group session. You agree that you will not dispute those charges ("charge back"), which may include but are not limited to (*please initial the following*):

- _____ Missed sessions with less than 48 hours notice and for appointments missed without notice.
- _____ I understand my card will be charged for returned checks for the amount of the check plus any fee imposed by the bank (typical bank fee is \$25 to \$35).
- _____ Balance of charges not paid within 7 days of service will be charged to my credit card on file.
- _____ Telephone contact in excess usually associated with services, i.e. calls in excess of 30 minutes on a weekly basis, prorated at the normal hourly rate, with notice given before charges are incurred.
- _____ I will not dispute charges for sessions I have received, appointments I have missed with less than 48 hours notice, or charges due to NSF checks.
- _____ I prefer to pay by credit card for each session, with a recurring charge of \$200 per 50-minute session or \$70 per group session.

If you have any questions or concerns regarding any part of this fee structure or billing/payment policies, please discuss these with your therapist as soon as possible. **This form will be securely stored in the client's clinical file and updated upon request at any time.**

Credit card type (circle one) Mastercard Visa American Express

Name as printed on card: _____

Card number: _____

Expiration date: _____ / _____ CVC / security code: _____

Billing address: _____

City: _____ State: _____ Zip code: _____

Cardholder signature: _____ Date: _____

Email to send receipt: _____