NewSong
Counseling Center

CREDIT CARD AUTHORIZATION FORM

NO SERVICES WILL BE RENDERED WITHOUT A COPY OF THIS FORM ON FILE. Our primary goal is to take care of all expenses at the time of services. We keep a copy in your CONFIDENTIAL record for the reasons below:

1) To bill any unpaid charges that may accrue as a result of having a deductible, co-payment, or coinsurance and or any other fees agreed upon that were not paid at the time of service delivery. Also to collect fees for individual, family, marital or assessment procedures that were not paid in full at the time of service or that were not paid by your insurance company, EAP program of Managed care company.
2) To bill any fail to keep appointment fees or cancellation fees that are not paid by you through regular contact or billing.
3) Any NSD or returned, unpaid check amount plus return check fees from your bank.

By providing the information below you agree to allow our office to bill the above mentioned fees and any other agreed upon fees located in the "Informed Consent: or "Fee Schedule" not paid by you in person, even if we are unable to contact you. You also agree that a $5.00 per charge fee will be added for using your card for unpaid fees that are not paid through a written or verbal request. You also agree that all NSF or unpaid checks will be charged an extra @25.00 charge plus the card fee. Your signature is authority to release your billing statement to your credit card company/bank for the purpose of collecting the appropriate fees charged to your credit card.

Name (exactly as it appears on card): _____

Type of card (Visa and MasterCard only): Visa _____ MasterCard _____

Card Number: _____

Expiration Date: Month _____ Year _____

Zip Code _____

Security Number (3 digits on back of card): _____

Is your billing address for this card the same as your home address: Yes _____ No _____

If **NO** please give us the correct address for this card:

_____

_____

Phone Number for card: Home Ph _____ Cell Ph _____ Other _____

_____ _____

Signature (client or Parent) **Date**

By signing this I hereby understand that my card may be charged for reasons stated above.
Would you prefer to use this card as your primary billing method? Yes _____ No _____

Name of NewSong Therapist _____