

CARING HEART

C O U N S E L I N G

Client Name: _____

Clinician: _____

ELECTRONIC PAYMENT AUTHORIZATION Please indicate the card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below. We accept: Visa, MC and Discover.

Client Information:

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Number: _____ Mobile Number: _____

Billing Information:

Please indicate the information associated with the credit card you wish to use, if different from client information.

Name on Card: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

Authorization:

I authorize all service fees to be deducted from the card ending in _____ (last four digits of the card)

I authorize the use of this card for all services and fees incurred for the following parties:

Full Name(s): _____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

Cardholder Signature _____ Date _____

Payments are processed by Therapy Partner. Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

Credit Card Information:

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one): Visa MasterCard Discover

Card Number: _____ Expiration Date: _____

Please enter the CVV code _____ (last three digits on back of card)