Restorative Healing Counseling & Psychotherapy

Authorization for Automatic Credit Card Payment

For your convenience, and to guarantee payment for services rendered, we request documentation of a major credit card.

I authorize Restorative Healing Counseling & Psychotherapy, LLC to keep my signature on file and to charge my credit card account listed below for deductibles and/or co-pays/co-insurance not collected at time of service, and for any current outstanding account balances over 30 days following insurance determination.

I authorize Restorative Healing Counseling & Psychotherapy, LLC to charge my credit card a $150.00 fee due to a missed appointment or a late cancellation (appointments cancelled with less than 24 hours notice). Please note that missed appointments and late cancellations will NOT be covered by insurance.

I understand that if my credit card is charged, I may be charged interest per my agreement with my credit card company. This interest can be substantial and the amount owed will increase with each partial payment to the credit card company if not paid in full.

I understand that this authorization is valid until I cancel the authorization through written notice to Restorative Healing Counseling & Psychotherapy, LLC or unless otherwise indicated.

____ Mastercard ____ Visa ____ Discover

Name on Card: _____

Card Number: _____

Expiration Date: _____ 3-Digit Security Code: _____

Billing Address: _____

_____

Client Signature: _____ Date: _____

Fill out, save and email to: nickilis@restorativehealingtherapy.com