Phone: 706-425-8900
Fax: 706-425-8600
Website: CA4wellbeing.com

Credit/Debit Card Pre-Authorization Form

I authorize _____of Counseling Associates for Well-Being to keep my signature on file and to charge my Visa or MasterCard Account for recurring charges of $_____ per therapy/counseling session. I also authorize charging my credit card for the full session fee for any appointment that is not kept or cancelled in accordance with our policy.
I understand that missed appointments are not reimbursed by insurance.

I understand this form is valid for two years unless I cancel the authorization in writing. I agree not to dispute charges ("charge back") for sessions I have received or not cancelled 24 hours prior to the scheduled appointment. I further authorize my provider to disclose information about my attendance/cancellation to my credit card issuer if I dispute a charge.

_____
Client name

_____
Cardholder name

_____
Cardholder Billing Address City, State Zip

_____ _____ _____
MC/ Visa/ disocover/ amex Account Number expiration date CVV code

_____
Cardholder Signature Date