I, _____, hereby authorize my therapist or clinician, at Counseling Associates for Well-Being [CAWB], to keep the card listed below on file in order to charge fees, or partial fees, for services provided to _____.

By signing this form, I authorize charging the full session fee for any appointment that is not kept or canceled, in accordance with our cancellation policy. I understand that missed appointments are not reimbursed by insurance.

By signing this form, I agree that:

- In the event that my card is invalid, I will immediately provide CAWB with a new card to be charged for the payment of any outstanding balance owed. I will also sign a new authorization reflecting the updated card information.
- This authorization is valid for 2 years, unless canceled in writing.
- I will not dispute any *legitimate* charges processed by CAWB.
- I further authorize my provider to disclose information about my attendance/cancellation to my credit card issuer if I dispute a charge.

Unless otherwise agreed upon, I understand that fees will be charged to my card on the same day that charges are incurred.

_____ _____ _____

Name Listed on Card | Billing Street Address | City

_____ _____ _____ _____

State | Zip | Card Type | Card Number

/ _____

Expiration Date | CVV Code

_____ _____

Signature | **Date Signed**