

Counseling Associates for Well-Being
Credit/Debit Card Authorization Form

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

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.

Name Listed on Card: _____ **Card Type:** _____

Card Number: _____ **Expiration Date.** ____/____

CVV: _____ **Billing Address:** _____

City: _____ **State:** _____ **Zip Code:** _____

SIGNATURE: _____ **DATE:** _____