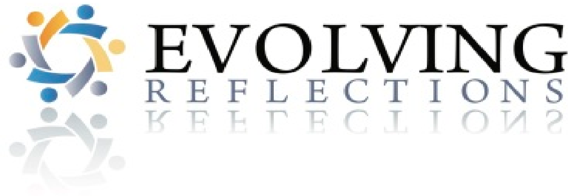

Credit Card Authorization Form

I, ____ (print name), am aware that the fees for the services provided by ____ (therapist name) are as follows:

- I understand that all fees are directly my responsibility to pay at the time of service.
- I understand that 24-hour notice is required for cancellations or I will be charged $125.00 for the missed session.
- Excessive cancellations or changing appointment times are disruptive to the therapeutic process as well as the therapist's schedule.
- I may be charged for any extra services requested. I understand that those charges will be discussed prior to services rendered.
- Services will not be rendered until fees have been paid.
- Insurance companies will be billed and paid directly to Evolving Reflections. I understand that I will be responsible for all outstanding monies not covered by the insurance company. For "Out of Network" insurance companies, paperwork can be provided (upon request) for you to submit a claim.
- Checks are accepted however, there will be a $50.00 charge for any returned check.
- If your account goes into Collections, there will be a 40% fee added to your balance.

I agree to take financial responsibility for my session(s). I will pay for services at the time they are rendered or in advance.

I authorize use of my credit/debit card by Evolving Reflections for payment, outstanding monies owed, as well as, missed appointments:

Card Type: ☐ Mastercard ☐ Visa ☐ American Express

Card Number: ____

Exp. Date: _______________ CVV: ____________

Cardholder Name: ____

Zip Code: _________________

Client Signature: ____ Date: ____________________

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