

CREDIT CARD AUTHORIZATION

I ask that you fill out this credit card authorization which I will keep in your file. You may pay for your sessions including co-payments, deductibles or any amount that is not covered by your insurance, with whichever method you choose. However, due to the billing system I use, your credit card will be charged automatically for sessions that are cancelled with less than 24-hours notice, missed sessions, and any amount that is not paid within 15 days of receiving an invoice. Any charges will show up on your statement as "Mental Edge Counseling, LLC." You may also receive emails requesting feedback of your transaction from the credit card processing company I use (SquareOne). You have no obligation to respond to those emails.

By signing this form, I hereby authorize Mental Edge Counseling LLC to charge my credit card for sessions that are cancelled with less than 24-hours notice, missed sessions, and any amount that is 7 days overdue on my account. I also authorize Mental Edge Counseling LLC to charge my credit card using a credit card processing system (for which I may receive emails requesting feedback about my transaction) for the balance due on my account including any co-payments, deductibles, or any amount that is not covered by my insurance. I certify that I am authorized to sign this form.

Credit Card Type: Visa Mastercard Other _____

Credit Card Number:

CCV: Exp. Date: /

Credit Card Billing Address

Name: _____
(As shown on CREDIT CARD)

Street: _____

City, State, Zip: _____

Card Holder's Phone: _____

Cardholder's Signature: _____

Printed Name: _____

Date: _____