



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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