# FAMILY STRATEGIES
COUNSELING CENTER

## Authorization for Automatic Debit/Credit Card Charges

*(updated 3/10/20)*

**Client Name**: ________________________________________ **Phone:** ______________________

**Parent/Guardian Name:** (If applicable) _____________________________________________

**INDIVIDUAL THERAPY:**

By my signature below, I authorize FAMILY STRATEGIES COUNSELING CENTER to debit/charge the account number I have specified below:

* At the time of service when I check in at the front desk, OR
* For missed appointments**,** OR
* For late cancelations. (Late cancelations are defined as up to 24 hours prior to my appointment.)

*Please be considerate of your therapist's time and abide by our 24-hour cancelation policy. If you notify us of a cancelation before 24 hours, it will allow us to schedule other clients seeking services here at Family Strategies.*

*Having a card on file to use for your sessions* **is required** *and will enable us to expedite your check in time and reduce overhead allowing us to keep fees as low as possible.*

CHECK ONE BOX: ☐ USE FOR ALL SESSIONS ☐ USE FOR NO SHOWS OR LATE CANCELATIONS ONLY

CHECK ONE BOX: ☐ **YES** ☐**NO** MAY WE **PRECHARGE** YOUR CARD WHEN YOU ARE SCHEDULED AT A TIME WHEN NO RECEPTIONIST IS AVAILABLE AT THE FRONT DESK (i.e. Saturdays, late or early hours.)

GROUP THERAPY: If you join a group, this credit card will be charged for group fees as well ***unless you notify us otherwise*****.**

ONE WEEK'S WRITTEN NOTICE IS REQUIRED TO CANCEL THIS AUTHORIZATION

**SIGNATURE :** ______________________________________________**DATE:** ________________________

**CREDIT CARD INFORMATION:** **Please check box:** ☐**VISA** ☐**MasterCard** ☐**Discover Card** ☐**Amex**

Name as it appears on the card: ____________________________________________________

Credit Card #: ____________________________________________________

Expiration Date: ________ CVV# *on the back of the card*: ________ **IS THIS AN HSA CARD?** ___________

**THIRD-PARTY PAYERS:** If a third party pays for all or a portion of your session fees, **we must have a signed Third-Party Agreement on file for you**. Please ask for this form at the front desk from the receptionist. Your credit card will not be charged unless your account is 60 days past due or beyond. We will contact you before charging your card.

Third-Party Payer Name: ______________________________________ Relationship to You: ____________

Address: ______________________________________________________________________________

*Street* *City* *State* *Zip*

Phone: ________________ Third-Party Payer Email: ________________________________________________