FAMILY STRATEGIES
COUNSELING CENTER

AUTHORIZATION for DEBIT/CREDIT CARD CHARGES

Revised 3.18.21

Client Name _____ Birthdate _____

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

- At the time of check-in
- The day of my telehealth appointment
- For missed (No Show) appointments
- For late cancelations. (Late cancelations are defined as up to 24 hours prior to my appointment.)

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 **PRE-CHARGE** your card when you are scheduled at a time when no receptionist is available at the front desk (i.e. Saturdays, early or late hours)? *Usually within 1 business day of your scheduled appointment.*

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

CREDIT CARD INFORMATION

Please check box: ☐ VISA ☐ MasterCard ☐ Discover Card ☐ Amex

Name as it appears on the card: _____

Credit Card #: _____

Expiration Date: _____ CVV#:_____ Billing Zip Code:_____

IS THIS AN HSA/FSA CARD? ▢ Yes ▢ No

_____

Cardholder Signature *Date*