Credit/Debit Card Authorization Agreement

This form will be securely stored in your clinical file and may be updated upon request at any time. It will **only** be used to cover the first appointment deposit, co-pays, private pay individual/couples/group sessions, and any late fees incurred.

I understand that I am required to provide **at least 24 hours advance notice** of cancellation, or "no show" for a scheduled therapy session, or my $50 deposit will be forfeited and changed to the credit/debit card on file. I further acknowledge that if I reschedule at the time of cancellation and/or **more** than 24 hours in prior to the original appointment, the $50 deposit will be applied to my next session co-pay, out-of-pocket fee, or kept on file as the deposit. Foundation for Healing, LLC will provide an accounting of all charges made to my card at the time of billing.

I will **not be charged** for any appointment that is missed/cancelled by my therapist, or for extenuating circumstances beyond my control at the scheduled time of service.

I, _____, authorize Foundation for Healing, LLC to store my credit/debit card information and to charge my credit/debit card for any and all fees outlined above. I agree not to dispute charges ("charge back") for sessions I have completed or missed according to the above policies.

Card Type: _____

Card #: _____ Expiration Date: ____/____

Name as Printed on Card: _____

Verification/Security Code (3 digit code on back of card by signature line): _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Signature: _____ Date: _____

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