Credit/Debit Card Payment Consent Form

Patient Name _____
Print Last **First** **Middle Initial**

Name on Card if different_____

I authorize *River Birch Counseling Center* to charge my credit/debit card for professional services as follows:

Initial

_____ (Optional) This visit only for the amount of $ _____,

_____ (Optional) All co-pays, co-insurances, or session charges, in the next 12 months,

beginning _____ /_____ /_____, to **_____ /_____ /_____**,

_____ **To charge my card for missed appointment fees, late cancellation fees, the balance of fees denied by my insurance company, or not paid by my insurance company within 90 days of date of service, and insufficient check amounts plus insufficient check fee of $30 per bad check. I authorize these charges to my card beginning _____/_____/_____ to _____/_____/_____ .**

Type of Card: ☐ Visa, ☐ MasterCard, ☐ Discover.

Card Number _____ - _____ - _____ - _____, CVV Number _____
A 3-digit number in reverse italics on the **back** of the credit card

Expiration Date _____

Email Address (for email receipts) _____

Card Holder's Billing Address for Credit Card Statements

_____

Street City State Zip

If I have questions about these charges, I agree to contact River Birch Counseling Center. I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

Card Holder Signature _____, Date ____ /_____ /____