brightside
counseling services, llc.

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Credit Card Payment Authorization Form

Please complete the following information. This form will be securely stored in your file and may be updated upon request at any time. This is your consent to make payment for services rendered via credit/debit card.

In case of late cancellations and/no shows for scheduled sessions, you will be charged your agreed upon fee. If a check is returned unpaid, you will be charged the amount the check is written for and an additional $35.00 is assessed for the returned check.

I, _____, hereby authorize *Brightside Counseling Services, LLC* and/or any of its agents to bill my credit card at the usual fee for professional services including all of the following:

-Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Appointments that I have cancelled with less than 24 business hours notice
- Returned checks (amount of check + $35.00)
-Credit card charge back (amount of service fee + $35.00)
- Fees not covered by insurance or insurance payments made to patient rather than provider

Client(s) name(s) that will be using services: _____

Credit Card Type (check one):
□ Visa □ MasterCard □ Discover □ American Express

Card #_____ Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (3 digit code on back of card by signature line or 4 digit code on front of AMEX):
_____

Billing Address: _____

City: _____ State: _____ ZIP: _____

By signing below I am authorizing *Brightside Counseling Services, LLC* and/or any of its agents to bill my credit card at the usual fee for professional services. I will not dispute charges ("charge back") for sessions I have received or appointments I have missed according to the above policy. By signing, I give consent for my information to be stored securely online for remote processing.
Signature: _____ Date: _____

Print Name: _____

Therapist Signature: _____ Date: _____