Be. Counseling Partners

Credit/Debit Card Authorization Agreement

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case that a check is returned you will be charged the session fee and an additional $45 returned check fee will be assessed.

I hereby authorize Be. Counseling Partners to bill my credit card the following fees for professional services including the following:

- Appointments (session fees or co-pays) that I elect to pay for by credit card. Please check your insurance benefits to know what the allowed amount will be per session if you have a deductible and/or what your co-pay will be per session.
- Late cancelled (less than 24-hour notice) or missed appointments will be charged $100.
- Returned checks will be charged usual session fee plus $45 additional fee

Insurance benefits:

My deductible amount is $_____ per year and/or co-pay per session is $_____.

The amount I can anticipate paying per session will be $_____.

Card type (check one): ☐Visa ☐Master Card ☐Discover ☐HSA ☐FSA

Card #:_____ Exp. Date:_____

Name as Printed on Card:_____

Verification/Security Code (3-digit code on back of card): _____

Billing Address:_____

City:_____ State:_____ Zip:_____

By signing below I am authorizing Be. Counseling Partners to bill my credit card/debit card at the usual fee for professional services. I will not dispute charges for sessions I have received according to the above policy.

_____ _____

Signature of Client/Parent/Legal Guardian Date