**Amanda Conner Counseling, LLC**

***CREDIT CARD AUTHORIZATION***

It is your consent to make payment for services rendered. This form will be securely stored in the clinical file and may be updated upon request at any time. Services being paid by anyone other than the client DOES NOT give them access to any of the client’s confidential information.

In the case of a missed appointment, failing to cancel an appointment within 24 business hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee. An additional $35 fee will be assessed for returned checks and inaccurately disputed chargebacks.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Amanda Conner Counseling, LLC to bill my credit card at the usual fee for professional services including all of the following:

* Appointments that I elect to pay for by credit card
* Missed appointments / No Shows
* Telephone and email consultations
* Appointments that I have cancelled with less than 24 business hours notice
* Returned checks / Inaccurately disputed chargebacks
* **There is a $2 service charge added to the usual fee for every credit card transaction.**
* For (client’s name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing below I am authorizing Amanda Conner Counseling, LLC to bill my credit card at the usual fee (plus $2 credit card transaction fee) for professional services as described above.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_