I _____ authorize Triad Counseling & Clinical Services, PLLC to keep my signature on file and charge my credit card at the full rate for any missed or late cancelled sessions. I understand that 24 hours notice is required for cancelling and rescheduling of all sessions. I recognize that if a balance on my account is accumulated in the case of a late-cancellation or no-show, I will not be rescheduled for future appointments until payment has been made.

I _____ authorize Triad Counseling & Clinical Services, PLLC to charge my credit card for the required payment of session at each date of service. This includes any co-pays, co-insurance, or other payments required for being seen.

Card Number: _____ _____ Security Code:_____

Expiration Date (MM/YY): _____ Name as it appears on card:_____

Card Billing Address:

_____

_____

I also authorize charges for the following individuals:

_____ _____

_____ _____

I verify that my credit card information, provided above, is accurate to the best of my knowledge. I understand that I am responsible for the entire amount owed. I also understand by signing this form that if no funds are available and alternate payment is not arranged, my balance will be sent to the collection agency.

_____

Printed Name

_____ _____

Authorized Signature of card holder Date