■ **A**. 550 222nd PL SE, Sammamish, WA 98074 ■ **P**. 425-369-1111 ■ **F**. 425-369-1112 ■ **W**. CrossPathCounseling.com ■ **E**. CPC@CrossPathCounseling.com

Credit Card Authorization Form

for CrossPath Counseling & Consultation

Please complete the following information. This form will be securely stored in your clinical file, may be updated upon request at any time and will be securely shredded no later then 6months after treatment is discontinued.

I, ______________________, authorize CrossPath Counseling & Consultation to charge my credit card for professional services. I agree that my card will be charged for balances of charges not paid by me or my insurance such as deductibles, co-pays and co-insurance.

Please Initial **ONE**:

_____Recurring charge for service in the amount of $_______ per visit

Agreement to monthly charges will be posted to the card on the 15th of every month or the next business day adjacent to the 15th.

_____ Recurring charges for services in the amount of $_______ per month.

_____ Recurring charge for ***any*** outstanding balance due on account including but not limited to: outstand copays, coinsurances, deductible amounts, missed appointment/no show fees.

Credit Card Information

Card Type: (Visa, MasterCard, etc) ____________________

Card #: ____

Expiration Date: _____________ Security Code: ________

Name as Printed on Card: ___________________________

Billing Zipp Code:_____________

I understand and agree that my card will be charged a fee of $65 for appointments I miss without 24 hour notice as agreed to in the *Appointment Fees* form I signed. This charge will be added to the card in the next billing cycle unless other payment arrangements are made.

Client Authorization

Printed Name: _____________________________Date:_____________

Signature:____