SHERMAN COUNSELING Improving Quality of Life | PACER | Baeten Counseling & Consultation Team | Delta Center Counseling Services | New Directions

Client's Name: ____________________________ DOB: ____/___/________

Credit Card Authorization

Sherman Counseling encourages keeping your credit or debit card on file as a convenient method of payment for the portion of services that you are liable for. This includes copays, co-insurance, deductible, No Show/Late cancel fee, etc. Your financial information is kept confidential and secure. **Effective 10/24/22 a credit card is required to be on file when doing telehealth sessions and must authorize payment to be made at the time of service.**

Please initial all statements that apply below:

_______ I authorize Copay/ co-insurance/ Self pay/ late cancel/ no show fees to be processed at the time of service and no later than the next business day. **This option is required for Telehealth**

_______ I authorize the entire balance to be charged to my card the first week of each month unless otherwise indicated
Exception – Day of each month to be billed: ___________________ (Example: 15th of each month)

Credit card information		
❑ Amex ❑ Visa ❑ Mastercard ❑ Discover	Credit Card #	
	Expiration: _____/____	CCV:
	Cardholder's Name:	

Card Holder Address: ____

City___________________ State _______ Zip________

Phone Number: (____) ______ - ______

Cardholder Signature: ________________________________ Date: _______________

I understand that this authorization will remain in effect until I cancel it in writing, the credit card expires or once I have paid my balance in full. I agree to notify Sherman Counseling in writing of any changes to my account information or termination of this authorization by the 1st of the next billing month. I certify that I am an authorized user of this credit card/ bank account and will not dispute these scheduled transactions with my bank or credit card company so long as the transactions are indicated in this authorization form.