CREDIT CARD AUTHORIZATION FORM

Worth Therapy requests that all patients keep an active credit card on file. Once providing this information, you are welcome to continue paying by cash or check, in which case you will only be charged in the below-listed circumstances. This form outlines my policies regarding fee collection; please read carefully and complete all fields. I’m happy to address any questions you might have.

The fee for (patient name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is $\_\_\_\_\_\_ for a 50-minute session. I prefer to:

☐ Pay at the time of each session via credit card.

☐ Pay at the time of each session via cash or check, but authorize Worth Therapy to charge my card in the event that I (or the individual bringing my child to session):

* Do not arrive for a scheduled session (fee charged at time of session)
* Forget payment in the form of cash or check (fee charged at time of session)
* Cancel within 48 hours (fee charged at time of late notice)

CREDIT CARD INFORMATION:

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| --- |
| Account Type: ☐ Visa ☐ MasterCard ☐ Discover  |
| Cardholder Name (as appears on card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Expiration Date: \_\_\_ / \_\_\_ CVV2 (3 digit # on back): \_\_\_\_\_\_\_\_\_\_ Billing zip code: \_\_\_\_\_\_\_\_\_\_\_ |

Notice: In the event you do not arrive to 2 consecutive sessions and do not respond to our office’s attempts to reach you by phone and/or e-mail, our office will not charge you for a 3rd missed session; rather, we will remove you from the calendar and will happily discuss rescheduling when you next reach out to our office.

By signing below, I certify that I am the authorized holder and signer of the above-listed credit card, and that all information I have provided is accurate. Additionally, I authorize Worth Therapy to charge my card in accordance with the above-outlined policies.

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