



Credit/Debit Card Authorization Form

All clients are asked to complete this form.

I authorize Tobin Counseling Group to charge my credit card for the following professional services:

- Appointments that I elect to pay by credit card;
- Missed appointments will be charged \$75;
- Appointments that I have cancelled with less than 24 hours-notice due to a non-emergency will be charged \$75;
- Checks with insufficient funds will be charged the amount of the check as well as a \$30 returned item fee charge;
- Co-payment and co-insurance as stated in my group plan;
- Balance of fees not paid by my health insurance company.

_____ (Initial)

Client Name: *Please Print* _____

Last

First

Middle Initial

Type of Card: (check one):

Visa

Mastercard

Discover

American Express

Name on Card (if different than above) _____

Card Number _____ - _____ - _____ - _____

Expiration Date ____/____

CW2/CID Security Code _____ (3 digit # from back of card)

Card Holder's Billing Address

Street

City

State

Zip Code

Card Holder Signature _____ **Date** ____/____/____