Credit Card Authorization Form

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I authorize Family Perspectives, LLC, to charge my credit/debit/HSA card for professional services as follows:

Please Initial each of the following except the first sentence unless applies:

______Charges for services in the amounts shown on consent to treat.

______$75 for telehealth or full session fee for in person appointment cancellations with less than 24 hours.

______Individual appointments I choose to pay by credit card.

______I understand that my card will be charged for returned checks for the amount of the check plus $35 per check.

______Balances of charges not paid including fees incurred in phone or internet treatment without payment rendered for 7 days.

______ I will not dispute charges for sessions I have received, appointments I have missed, or charges due to bounced checks.

I, ____ , am authorizing Family Perspectives, LLC to bill my credit card in the even of any appropriate scenario initialed above.

Charges will appear on your credit card statement as familyperspectives@gmail.com 480-277-0049

Card Type (circle one): Visa MasterCard Discover American Express

Card #: ____________________________________

Expiration Date: ______________________________

Name as Printed on Card: _____________________________

Verification/Security Code (3-digit code on back by signature line-MC/Visa/Discover; code above card number, upper-right hand side-AmEx): ___________

Billing Address: ____
(Street, City, State & Zip)

Signature: ____

Date: _________________

Revised 11-2-23