Your Story Matters Counseling
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Authorization for Credit Card Use

I, _____ authorize Your Story Matters Counseling LLC. to charge my credit/debit cared for the following:

- ☐ Individual, couples or family counseling/consultation sessions
- ☐ For any appointments missed or canceled with less than 24 hours notice
- ☐ Copay or coinsurance rate for all attended appointments
- ☐ Any portion of billable services not covered by client's insurance policy
- ☐ Other

Credit Card Information				
Card Type:	Master Card ☐	Visa ☐	Discover ☐	Amex ☐
Cardholder Name (as shown on card):				
Card Number:			Security Code:	
Expiration Date: (mm/yy)				
Cardholder Zip Code: (from credit card billing address)				
Email for receipt to be sent:				

I, _____, understand that payment is due at the time of service, including treatment expenses not covered by insurance, missed appointments, and copayments. I will have the option of paying with check, cash or credit card at the time of service. If I have an outstanding balance or a missed appointment, I authorize Your Story Matters Counseling LLC. to use this credit card information as payment for services.

_____ _____

Client Signature Date