Openings Counseling
LLC

Credit Card Authorization Form

I hereby authorize Openings Counseling, LLC, c/o Susan Scott, MS, MFT to charge the credit card listed below for payment of fees which are incurred by the authorized user(s) and family.

Name: ____ Date: __________________
(as it appears on card)

Credit Card Billing Address:

____
Street City State Zip Code

Card Type: (Please Check One): [ ] Visa [ ] Mastercard

Credit Card Number: ____ Expiration Date: ______________________
CCV Code (3 digits on back of credit card): ________

Please select one of the following payment options:

[ ] Bill my credit card once for the following amount: $ ______________
[ ] Bill my credit card after each session $ 125.00

No-Show Appointments Automatic Billing

[X] My credit card will automatically be billed when I do not arrive for a scheduled appointment without 24 hour advanced notification.

Credit Card Billing Policy

I give my permission for Susan Scott MS, LMFT to bill my credit card for services rendered including individual, couple and family therapy.

I understand that my credit or debit card will be charged the full session fee amount of $125 automatically in the event of a missed appointment where the minimum 24 hour notification was not given.

I understand that if I decide to terminate any of the services provided by Susan Scott, MS, LMFT and my account is paid in full, I may withdraw the authorization to charge my credit in the future provided I communicate revocation of authorization in writing to Openings Counseling, LLC c/o Susan Scott, MS, LMFT.

I agree that all information provided is accurate and complete. I also acknowledge that if any charges are declined or charge backs are claimed against any outstanding invoiced amount, I will be expected to pay the invoiced amount plus any added costs and fees in cash. If this is not paid, the statement may be sent to a collection agency.

I understand that my credit or debit card will be charged in the case of a delinquent balance (15 days after an account statement requesting amount due has been sent).

I understand and accept all of the terms regarding this billing policy.

Name: ____ Date:________________________

Signature: ____

Susan Scott MS, LMFT OpeningsCounseling@gmail.com (860) 510-3310