



CREDIT CARD AUTHORIZATION FORM

CLIENT NAME: _____

DATE: _____

We require your credit card information for several reasons:

- 1) If you do not comply with our cancellation policy, then your therapist will charge your card the missed appointment fee or the late cancellation fee. Missed appointments and cancellations made less than 24 hours in advance will be assessed for 25% of the full session fee for the first occurrence, 50% of the full session fee for the second occurrence, and 100% for the third occurrence. After two missed appointments with no prior notification, Downtown Behavioral Health (Lindsay Burleson, LLC / Maggie Futch, LLC / Chloe Hammick, Intern / Sydney Buchan, Intern) reserves the right to cancel all upcoming appointments for that client and/or may require prepayment for future appointments. This fee cannot be submitted to insurance and insurance cannot be billed for a missed session.
- 2) In the event that you have an outstanding balance past 90 days, your card will be charged for the outstanding balance within 15 days if you do not call your therapist to make partial or full arrangements for payment.
- 3) Your therapist can charge your card at the time of each session. **This is optional and your therapist will ask how you would like to pay for each session before charging your card.** *Please note, the fee for charging saved cards is slightly higher than the processing fee indicated in the new client paperwork financial policy.*

You will be notified in writing or via email of any charges made to your credit card account.

I, _____ (print name as it appears on the credit card), authorize Downtown Behavioral Health (Lindsay Burleson, LLC / Maggie Futch, LLC / Chloe Hammick, Intern / Sydney Buchan, Intern) to submit any charges for professional services or fees that are rendered to _____ (print full legal name of client receiving services) to my credit card. This authorization applies to all legitimate charges for any individual whom I have accepted financial responsibility and includes all current and future outstanding charges.

I promise not to dispute charges ("charge back") for sessions I have received or for fees associated with non-compliance with the cancellation policy. I further authorize Downtown Behavioral Health (Lindsay Burleson, LLC / Maggie Futch, LLC / Chloe Hammick, Intern / Sydney Buchan, Intern) to disclose information about my attendance/cancellation to my credit card issuer if I dispute the charge.

I understand that this information will be kept in a secure location to ensure its safety and protection. If my credit card expires, I will provide updated information.

Full legal name of client authorized for use: _____

Name on Credit Card: _____

Type of Credit Card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover ☐ Other_____

Card Number: _____

Exp. Date: _____ Card Verification (CVV) Code: _____ Billing Zip Code: _____

Email Address: _____

Signature of Cardholder: _____ Date: _____