Revised 10/10/2017

Credit Card Authorization Form

At Integrative Counseling Services, PC we allow a credit card to be kept on file as a convenient method of payment of copays, deductibles, or private pay services. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer (if applicable), and the insurance portion of the claim has paid and posted to the account.

Patient Name: _____ DOB: _____

I authorize Integrative Counseling Services, PC to charge the portion of my bill that is my financial responsibility to the following credit card.

□Amex □Visa □MasterCard □Discover

Credit Card Number: _____

Cardholder Name: _____

Expiration date: _____/_____/_____ Security Code: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Receipt Desired: □Yes □No Email Address for Receipt: _____

I understand the undersigned, authorize, and request Integrative Counseling Services, PC to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

The authorization relates to all payments not covered by my insurance company for services provided by Integrative Counseling Services, PC.

This authorization will remain in effect until I cancel this authorization. Cancellation of this authorization must be received in writing.

Cardholder Signature: _____ Date: _____