Helping Others Heal

Counseling to restore love and wholeness

Credit Authorization Form

By signing this agreement, you are authorizing Adrian S. Turner, M.A., LMFT/Helping Others Heal to charge the credit card provided for all professional services rendered to you, the "Client," that are not paid at the time of service, or for situations which fall under the Late Cancellation or denied insurance claims listed in your Consent for Treatment agreement. I agree that I will not dispute those charges ("charge back"), which may include but are not limited to the following:

- The $80 fee if the client does not show for an appointment and has not cancelled at least 24 hours prior to the session as outlined in the cancellation policy;
- Deductibles, excluded services, insurance payments made to someone other than the provider or other charges that have not been directly reimbursed by insurance;
- Checks that are returned by the bank will incur a $40 fee as well as the amount of the check.

If you have any questions or concerns regarding any part of the fee structure or billing/payment policies, please discuss these with me prior to signing this form. Your signature is acceptance of this policy.

Credit Card Type (check one):

___Visa ___ Mastercard ___Discover ___ American Express

Name as printed on card: _____

Card #: _____ HSA/FSA card? Yes No

Expiration Date (MM/YY) _____

3 or 4 digit verification/security code on back/front of card: _____

Billing address: _____

City: _____ State: _____ Zip: _____

Telephone Number (to receive receipt for charge): _____

Signature of Payer: _____

Printed Name of Payer: _____

Please initial each of the following as acceptance that:

____Charge for sessions cancelled with less than 24 hours' notice and for appointments I miss without notice which will be billed to my card for that purpose ($80);

____I understand my card will be charged for returned checks for the amount of the check plus $40.00.

____Balances of charges not paid within 14 days of service, or not paid by insurance, will be charged on the credit card.

____I will not dispute charges for services I received, appointments I have missed with less than 24 hour's notice or no notice or charges due to returned checks.

Client Signature: _____

Date: _____

This form will be kept securely in the client's clinical file and can be updated by the client at any time.