Compass Professional Counselors, LLC
359 S. Mountain Blvd. Mountain Top, PA 18707

AUTHORIZATION TO CHARGE CREDIT CARD

I authorize regularly scheduled charges to my Visa, MasterCard, American Express or Discover card.
I Authorize **Compass Professional Counselors, LLC**:
to charge my card for missed appointment fees, late cancellation fees, the balance of fees denied by my insurance company, or not paid by my insurance company within 90 days of date of service, and insufficient check amounts plus insufficient check fee of $30 per bad check. I authorize these charges to my card beginning _____/_____/_____ to _____/_____/_____ .
If I have questions about these charges, I agree to contact **Compass Professional Counselors, LLC**. The charges will be labeled "**VTG Compass Professional Counselors, LLC**" on my credit card statement not by my provider's name due to confidentiality. I agree that I will not pursue a refund directly through my credit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.
*__Debit Cards are not Permitted. FSA cards are accepted.__

Initial below:

_____

Please complete the information below:

I, _____ , authorize **Compass Professional Counselors, LLC** to
Name (as it appears on credit card)
charge my credit card, indicated below, on or after the day in which I receive my therapy session.

I understand that I will only receive a **5-day** advance notice of the charge if it exceeds $**150.00**

Billing Address _____ Phone#_____

City, State, Zip _____ Email _____

Please make sure the following information is accurate.

Account Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date (MM/YY) _____

CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____