HEAD/HEART
UNIQUE THERAPY FOR UNIQUE PEOPLE

CREDIT CARD AUTHORIZATION FORM

Please note that the information on this form will be securely entered and stored in a HIPAA compliant on-line virtual terminal that is password protected for your safety. Once your information has been entered to the secured terminal, these paper forms will be shredded and destroyed immediately to protect your information. While all secure methods to protect your information are in place, and we take your safety seriously, no company can 100% guarantee that any on-line system cannot be breached, thus you are accepting responsibility and risk in allowing Head/Heart Therapy to store your information for therapy charges.

I authorize my therapist with Head/Heart Therapy, Inc. to keep my signature and card information on a virtual terminal file that is password protected and HIPAA compliant in order to charge therapy session fees (individual, group, workshops, couples, family or other), and any fees related to therapy related materials (workbooks, DVD's, CD's, and other materials, and or fees), or for any appointments with my therapist that are not cancelled 24 hours before the scheduled appointment time to be charged to my credit, charge, or debit card as filled out below for therapy services provided to:

_____

(Client name – Please print)

I understand that this authorization is valid until canceled in writing. I understand that though this information is secured in on-line protected client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I understand that charges for on-going services or materials will normally be posted to my credit/debit/flex card account within 48 hours of each session date. Additionally, I agree that the card listed below may be charged by my therapist with Head/Heart Therapy, Inc. in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials [i.e. books, CD's, DVD's] that I have not returned within one week of termination. I understand that if a charge back fee is incurred or a retrieval fee of is incurred I am responsible for these fees. Initial _____

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact my therapist with Head/Heart Therapy for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with my therapist and those attempts have failed. Initial _____

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Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by this persons therapist at Head/Heart Therapy. Initial _____

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Name [print]:_____

Signature_____

Relationship to client:_____

Billing Address:_____

Zip Code: _____

Number: _____-_____-_____-_____ Exp. Date: _____

CVV Code (3-digit code on back of card): _____

I understand that therapy sessions for the client will be charged via this payment form unless otherwise discussed with my therapist:

Cardholder Signature: _____ Date: _____