DALLAS COUNSELING & TREATMENT CENTER

CREDIT CARD AUTHORIZATION FORM

By signing this form, you give Dallas Counseling and Treatment Center (DCTC) permission to charge your credit card for any amount due as outlined below.

THIS FORM GIVES PERMISSION TO:
(1) Charge for late cancellations (less than 24 hours' notice provided), late arrivals, and missed appointments which will be charged to you at the full rate of the negotiated insurance amount or the full private pay rate if you are not using insurance. A fee equal to 100% of the scheduled service is charged for all sessions canceled with less than 24 hours' notice. Insurers do not pay for missed sessions; therefore, clients are responsible for the full amount of each scheduled service without insurance benefits applied.

(2) Charge the retainer fee for a court appearance legally required by a subpoena. For more information on court fees, please refer to the Counseling Policies.

(3) Charge for a remaining balance that insurance has denied or deemed the member's responsibility on an insurance EOB unless you set up a payment plan or offer another form of payment within 24 hours of our first attempt to contact you. Please note that we communicate via email so you will receive this notice in that manner. We attempt to verify insurance in advance but cannot guarantee coverage until claims are processed by your insurance company.

(4) Charge for any ensuing fees as a result of you challenging legitimate charges on your credit card as evidenced by a favorable decision by your bank on the part of DCTC.

Client's Full Name: _____

Therapist: _____

I, (Cardholder's Full Name) _____ *, authorize Dallas Counseling and Treatment Center to charge the credit/debit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit/debit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form. If sent by email, my typed signature constitutes my legal binding signature.*

Account Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express
☐ Health Savings Account (HSA) ☐ Flex Spending Account (FSA)

Cardholder's Name: _____

Card Number: _____

Exp. Date: _____

Security Code: _____
(3-digit number on back of card or 4-digits on front of Amex)

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Cardholder's Signature: _____ Date: _____