



CREDIT CARD ON FILE POLICY

At Sacred Space Counseling, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable, including charges for late cancellation or no show fees. Without this authorization, a billing fee of \$5 will be added to your account for any balances that we must attempt to collect through mailing monthly statements. Furthermore, an "outstanding balance" charge of 1.5% of the total bill will be charged for each month that the bill remains unpaid.

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, and the insurance portion of the claim has paid and posted to the account.

I authorize Sacred Space Counseling to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Amex Visa Mastercard Discover

Credit Card Number _____

Expiration Date ____/____/____ **CCV code** _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State** _____ **Zip** _____

I (we), the undersigned, authorize and request Sacred Space Counseling to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Sacred Space Counseling, including fees for late cancellation or no shows.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Sacred Space Counseling in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: ____/____/____