



Credit Card Authorization Form

I, _____ authorize Water's Edge Counseling & Therapeutic Services, LLC to
(name of client)

charge my credit/debit card for the following:

(Initial all that apply)

_____ \$ _____ for all individual, couples, or family counseling/consultation sessions

_____ Copay or coinsurance rate for all attended appointments

_____ \$ _____ for any appointment missed or canceled with less than 24 hours' notice

_____ Any portion of billable services not covered by my insurance policy

_____ Other: _____

Name Printed on Card: _____ Type of Card: _____

Credit Card Number: _____ Expiration Date: _____

CVC 3- or 4-Digit Code: _____ Billing Address Zip Code: _____

By signing below, I certify that the above information is true and accurate and that I am an authorized user on the credit card/debit account above. I authorize Water's Edge Counseling & Therapeutic Services to keep my credit card information on file and charge the above fees automatically and on an ongoing basis until or unless I cancel these automatic payments in writing. I understand that I am responsible for notifying Water's Edge Counseling & Therapeutic Services if my credit/debit card information needs to be updated. Water's Edge Counseling & Therapeutic Services agrees to ONLY charge for services rendered or for appointments not cancelled 24 hours in advance. I understand that if I wish to cancel an appointment I will need to speak with an employee of Water's Edge Counseling & Therapeutic Services, send an email to the correct email address of my counselor, or leave a recorded voicemail message at (727) 386-6213.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____