IMARA
COUNSELING SERVICES

CREDIT CARD AUTHORIZATION FORM

Instructions: *Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled. This information will be stored with client files according to HIPAA regulations.*

CREDIT CARD INFORMATION

CARD TYPE: ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX

CARDHOLDER NAME (*as shown on card*): _____

CARD NUMBER: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

EXP. Date: _____/_____ CVV: ____ ____ ____ BILLING ZIP CODE: _____

I, _____ authorize Imara Counseling Services to charge my credit card for any balances on my account, that may also include co-pays and deductibles if not paid at time of service. In the event that I do not cancel an appointment within 24 hours or I am a no show, I authorize that my credit card be charged the full cancellation fee as outlined in the consent to treatment, and the cancellation policy form.

I authorize Imara Counseling Services to charge the credit card that I place on file according to the terms above. This payment authorization is for the services described and the amount indicated in the informed consent and/or quoted by my Imara Counseling Services' therapist.

I certify that I am an authorized user of this credit 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. I understand that if my card is declined, I am still responsible for paying the full cancellation fee within 7 days of my missed scheduled appointment. If I do not pay within 7 days, I understand that a 10% late fee will be applied to my total balance. If I do not pay within 30 days, I understand that my balance and information needed to collect payment may be sent to a collection agency.

_____ _____/_____/_____

Credit Card Holder/Authorized User Signature **Date**

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