Authorization to Secure Payment for Services Rendered

A New Day Family Counseling

I, _____, authorize A New Day Family Counseling to process payment on my Visa, MasterCard, or Discover Card for services and/or for any balance due that has not been paid.

Payment Terms and Conditions

Payments may be applied to co-payments, co-insurances or balances due to annual insurance deductibles not met.

Payment will be processed at the time of the appointment or the next day. If the credit card on file is declined, A New Day Family Counseling will attempt to process the payment on another day when funds become available.

Please be aware that all appointments needing to be cancelled or rescheduled require a 24-hour notice, otherwise a fee of $85 will be charged to your card. By signing this authorization, you agree with these terms.

I have read and understand these payment terms and conditions. I attest that the information below is true and accurate.

Signature of Card Holder: _____

Cardholder's Name _____ Client Name _____

Credit Card Account Number _____Exp. _____ CCV Code _____

Is this a Debit Card? Y N Today's Date _____

Amount of Co-Pay _____Email Address_____

Zip Code _____