Counseling Center of Montgomery County

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PREAUTHORIZATION FOR CREDIT CARDS

I authorize COUNSELING CENTER OF MONTGOMERY COUNTY to keep my signature on file and to charge my MASTERCARD / VISA / DISCOVER / DEBIT / OTHER: _____ account for:

_____ All balances not paid by insurance or other third-party payers after 60 days, to avoid an interruption of services. This total amount cannot exceed $ _____.

_____ Recurring charges (ongoing treatment) as per amounts stated in the signed Financial Contract for services rendered by CCMC.

_____ Fees related to case management in order to execute services in a timely manner (a bill summary will be provided to explain the costs, per the client request).

____ Fees to cover the non-refundable expenses for court (a bill summary will be provided to explain the costs, per the client request).

____ To cover any NO SHOW fees in accordance with the NO SHOW contract to alleviate an interruption of services.

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to this clinic. I understand that CCMC will provide me with a receipt after the transaction is completed, per my request. By signing this contract, I am aware of and agree to the 3.5% surcharge fee for each transaction that is charged to my credit card. To avoid the surcharge fee, we accept cash or money order at the office.

Client's Name: _____

Cardholder's Name: _____

Cardholder's billing address: _____

City: _____State:_____Zip:_____

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

Cardholder's Signature: _____ Date: _____