



NIA COUNSELING & FAMILY SERVICES, PLLC

WHERE CULTURE, MEETS CARE



+19193075320



Niafamilylife@gmail.com



Www.NiaFamilyLife.com

Payment Authorization Form

Nia Counseling and Family Services, PLLC
4030 Wake Forest Rd. Ste. 349
Raleigh, NC 27609
919-307-5320
niafamilylife@gmail.com

Patient Information:

Patient Name: _____
Date of Birth: _____
Address: _____
City, State, Zip Code: _____
Phone Number: _____
Email Address: _____

****Payment Authorization**** I, the undersigned, authorize Nia Counseling and Family Services, PLLC to charge my credit card for therapy services rendered. I understand that I am responsible for payment of all services provided, including any co-pays, deductibles, or outstanding balances.

Credit Card Information

Cardholder Name: _____
Card Number: _____
Expiration Date (MM/YY): _____
CVV: _____

Billing Address (if different from patient address)** -

Address: _____
City, State, Zip Code: _____

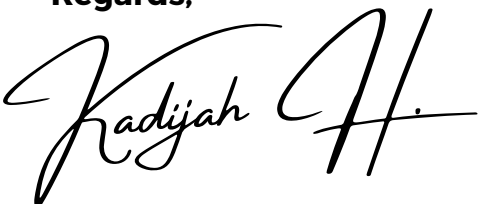
****Authorization Agreement**** I authorize Nia Counseling and Family Services, PLLC to charge my credit card for the services provided. I understand that this authorization will remain in effect until I provide written notice to cancel it. I acknowledge that I have read and understand the terms of this payment authorization.

:

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

CLIENT SIGNATURE _____ DATE _____

Regards,

A handwritten signature in black ink, appearing to read "Kadajah H." with a stylized flourish at the end.

Kadajah Harris, LCSW

Outpatient Therapist