

NEW HORIZONS COUNSELING, LLC

4578 William Penn Highway, Murrysville, PA 15668 (724) 972-6409

Joan McCullough-Crissman, MA, LPC

CREDIT CARD PROCESSING AUTHORIZATION FORM

Name (print) _____

Name (as it appears on card): _____

Email: _____

Card Type: VISA: MASTERCARD: HSA: DISCOVER: DEBIT:

Credit Card Number: _____

Card Expiration Date: _____ Security Code : _____
(Three-digit number on back of card)

Statement of Authorization:

My signature authorizes New Horizons Counseling, LLC to keep credit card information on file and to bill charges associated with the counseling services provided to me or my family member to my credit card account. This could be fees for copays, coinsurance, deductibles or private pay office visit.

I understand that I can question a charge, or reverse a charge at any time by calling 724-972-6409. At the completion of treatment, this credit information will be discarded.

I agree to notify the office if my credit information changes, and will take responsibility for any surcharge that is incurred by a voided transaction caused by incorrect credit card information. If your card is not active for some reason at the time of service, I will use the card information you supply at that time with the same permissions and acknowledgements of billing and payment.

Signature: _____

Date: _____