CCIA, LLC
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Gary G. Kindley, D.Min., LPC, CSAT **Erin L. Wysong, MS, LPC, LCDC, CSAT**

CREDIT CARD AUTHORIZATION FORM

Please note that this form will be securely stored in your clinical file and that you assume the risk for keeping this information on file.

I authorize therapist:

_____ Gary Kindley, D.Min., LPC, CMAT, CSAT

_____ Erin Wysong, MS, LPC, LCDC, NCC, CSAT

doing business as CCIA, LLC to keep my signature and card information on file and to charge therapy session fees (individual, group, workshops, couples, family or other), cancelation fees (48-hour cancelation notice required) and any fees related to therapy related materials (workbooks, DVD's, CD's, and other materials) to be charged to my credit, charge, or debit card or flex spending account as filled out below for therapy services provided to:

_____
(Therapy Client's Name: Please Print)

_____ (*initial*) I understand that this authorization is valid until canceled in writing. I understand that though this information is secured in my client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I understand that charges for on-going services or materials will normally be posted to my credit/debit/flex card account within 72 hours of each session date and **my session fee will be charged at the start of the session.** Additionally, I agree that the card listed below may be charged by therapist above doing business as CCIA, LLC in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including sessions fees for non-cancelation of appointment 48 hours prior to the scheduled session, as well as any materials [e.g. books, CD's, DVD's] that I have not returned within one week of termination. I understand that if a charge back fee is incurred or a retrieval fee is incurred I am responsible for these fees.

_____ (*initial*) I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact therapist above for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with therapist above and those attempts have failed.

_____ (*initial*) Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by therapist above.

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Signature: _____

Cardholder Name [print]: _____

Relationship to client: _____

Card Type (circle one): Visa Mastercard Flexible SA Debit

Acct. Number: _____

Exp. Date: _____

Security Code: _____

Billing Zip Code: _____

I understand that my therapy sessions will be charged via this form if session is not cancelled at least 48 hours in advance:

Cardholder Signature: _____

Date: _____