



CLIENT ACKNOWLEDGEMENT OF CREDIT CARD AUTHORIZATION

Reminder calls are a courtesy and do not negate my responsibility for my sessions. I agree to provide the office a minimum of 24 hours' notice if I need to cancel/ reschedule my session. This office does its best to stay on schedule. As such, we do not overbook appointments. Scheduling an appointment fills a slot on a TBC for CBT therapists' schedule. Missing therapy appointments or arriving late not only disrupts the flow of the schedule, but also is not fair to other scheduled clients or to those who may need to be seen on an urgent basis. Additional fees may be charged for extra services, such as for letters or other documentation needed or requested. Additional fees may also be applied if crisis phone-coaching surpasses the standard 15-minute coaching call period. Your therapist will inform you of these possible extra fees at the time of request for the extra service.

I understand that I will be held financially responsible for any individual or group therapy sessions I miss with my provider, regardless of given notice. This means that I can still be charged up to my regular rate for individual/group therapy if I miss a given session.

I understand that for group therapy, clients commit to attend the group on a per-module basis, meaning I can be charged for each session in each module (6 sessions total; \$60-80 per group) I commit to, regardless of attendance. Any disputes about these charges are to be discussed with my provider.

I give my permission to keep the following credit card information on file for any unpaid balances and that I will receive electronic notification if my card is charged:

PLEASE PRINT

Name of Client: _____

Name of Cardholder (as shown on card): _____

Complete Billing Address (+ Zip): _____

Email address of cardholder: _____ Phone #: _____

Debit: _____ Credit: _____ AMEX VISA MC Discover

Card Number: _____ Expiration Date: _____

Three/Four Digit CID Number: _____

_____ I understand my card will be billed in the event of the aforementioned, the equivalent of two weeks' worth of fees accumulated without payment.

_____ I would like to have my credit card charged for all sessions held.

_____ I understand if my account is turned over to a collection agency for non-payment, I will be responsible for the collection agency fee as well.

Cardholder Signature

Date

Witness/TBC Staff

Date

Nancy S Gordon, LCSW
President/Founder

PO Box 14 Brandon, FL 33509
219 Cook St. Brandon, FL 33511
<mailto:admin@tbcbforbt.com>
www.tbcbforbt.com

Office: (813) 480-8482
Fax: (813) 251-4402

Updated 3/17/21