Authorization to Secure Payment

I, _____authorize Anew Family Counseling Center to process payment on my Visa, MasterCard, Discover or other form of electronic payment for any balance due that has not been paid including no show or late cancelations fees incurred by the client (please review cancellation/no show policy).

I understand that I have provided Anew Family Counseling Center with my credit card information. I further understand that if I miss a scheduled appointment or fail to provide 24 hours' notice (regardless of reason), my credit card may be charged the full amount of the session.

I have read and understand this form.

I attest that the information below is true and accurate.

My credit card information will be scanned into a SECURE HIPAA patient record and held to the privacy laws in the state in which services are rendered.

Credit Card Holder Information

_____ _____ _____

Credit Card Holders Name Zipcode Client Name

_____ _____ _____

Credit Card Number Expiration Date CVV

Circle One: Visa Mastercard Discover American Express

I authorize Anew Family Counseling Center to charge my credit card for any co-pays, cancellation or late fees applied to my account.

_____ _____

Cardholders Signature Date