



Payment Authorization Form

Please complete the following information. This form will be securely stored in your file and may be updated upon request at any time. This is your consent to make payment for services rendered via credit/debit card. In case of late cancellations and/or no-shows for scheduled sessions, you will be charged your agreed upon fee. If a check is returned unpaid, you will be charged the amount the check is written for and an additional \$35.00 for the returned check penalty fee.

I, _____, hereby authorize Trade Winds Therapy, LLC & Relationship Coaching to bill my credit card at the agreed upon fee for professional services including any of the following:

- Appointments and/or co-payments that I elect to pay for by credit/debit card
- Missed appointments
- Appointments that I have cancelled with less than 24 hours notice
- Returned checks (amount of check + \$35.00 additional fee)
- Credit card charge back (amount of fee + \$35.00 additional fee)
- Fees not covered by insurance or insurance payments made to client rather than provider

Client(s) name(s) who will be using services: _____

Card type (check one):

- Visa MasterCard Discover American Express

Card # _____ Expiration Date: _____ / _____

Name as printed on card: _____

3 or 4 digit security code: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

By signing below, I am authorizing Trade Winds Therapy, LLC & Relationship Coaching to bill my card at the agreed upon fee for professional services. I will not dispute charges (“charge back”) for sessions I have received or appointments I have missed according to the stated policy.

Client Signature: _____ Date: _____

Printed Name: _____

Therapist Signature: _____ Date: _____