Rachael Rutter DeKoning, LCMFT, LLC

CPSKC

8575 W. 110th St. Suite 218

Overland Park, KS 66210

Credit Card Authorization Form

Your therapist requires a credit card on file. The credit card will be automatically charged for the balance of any outstanding accounts that are not settled within 60 days of service. You will be notified of any balances before your card is charged. When paying at the time of service, you can pay with cash, check, or card.

Today’s Date: \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Annual Household Income\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of household members \_\_\_\_\_

**Payment Agreement**

**I will pay in person at the time of service**

I will pay a full or estimated amount of my financial responsibility with each visit by cash, check, or card. I understand my credit card will be automatically charged for any balance left 60 days after the time of service. Additionally, I understand that Rachael Rutter DeKoning, LCMFT, LLC reserves the right to charge the full fee when payments are not made at the time of service.

**Bill me (the ability to pay scale is only valid with payment at the time of service)**

This includes sessions by phone or in person, reports, and/or late cancellation fees. I understand my credit card will be automatically charged for any balance left 60 days after the time of service. Additionally, I understand that Rachael Rutter DeKoning, LCMFT, LLC reserves the right to charge the full fee when payments are not made at the time of service.

**Credit Card Information and Authorization**

Name as it appears on the card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of card: Visa Mastercard

Credit card number: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Security Code: \_\_\_\_ Expiration Date\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize this card to be used for service charges at Rachael Rutter Dekoning, LCMFT, LLC.

Cardholder signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**

I understand and agree to the terms and conditions on this form.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_**