

PRE-AUTHORIZED HEALTH CARE FORM

I authorize Anchor to Hope Counseling, LLC to keep my signature on file and charge my credit card account through Ivy Pay for:

* Charges for services rendered
* Charges for missed appointments (including those not canceled within 24 hours)
* Balances of charges not paid by me within 30 days
* Copay and Co insurance charges

I understand that I may revoke this agreement at any time by providing a request in writing.

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

* VISA
* Master Card
* Discover
* American Express
* Health Savings Account

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anchor to Hope Counseling, LLC agrees to charge only for reasons agreed upon in Psychotherapy, Supervision, or Consultation agreement.