Bystrom Counseling and Consultation
2627 27th Avenue South, Suite #231
Minneapolis, MN 55406

Credit/Debit Card Authorization Agreement

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case that a check is returned unpaid, you will be charged the session fee and bank fees for non-sufficient funds will be assessed. There will also be a $30 "charge back" fee for each disputed credit card payment.

I hereby authorize Bystrom Counseling and Consultation, LCC, to bill my credit/debit card for the following fees for professional services including the following:

- Appointments (session fee or co-pays) that I elect to pay for by credit card. Please check your insurance benefits to know what the allowed payment per session will be if you have a deductible and/or what your co-pay will be per session.
- Late cancelled (less than 24 hours notice) or missed appointments will be charged $75
  -Exceptions include personal or family emergency and/or if the therapist schedule can accommodate a rescheduled appointment within the week
- Returned checks will be charged the usual session fee plus bank fees

Insurance benefits:

My deductible amount is $_____ per year and or co-pay per session is $_____.

The amount I can anticipate paying per session will be $_____.

Card type (circle one): Visa Mastercard Discover HSA/Flex Spending

Card #:_____ Expiration Date:_____

Name as printed on card: _____

Verification/Security Code (3-digit cod on back of the card):_____

Billing address:

Street:_____

City:_____ State: _____ Zip: _____

By signing below, I am authorizing Bystrom Counseling and Consultation to bill by credit/debit card at the usual feel for professional services. I will not dispute charges ("charge back") for sessions I have received according to the above policy.

_____ _____
Signature of Client/Parent/Legal Guardian Date