Client Credit Card Authorization Form

Please note that the information on this form will be securely entered and stored in a HIPAA compliant online virtual terminal that is password protected for your safety. Once your information has been entered by me to the secured terminal, these paper forms will be shredded and destroyed immediately to protect your information. While all secure methods to protect your information are in place, and we take your safety seriously, no company can 100% guarantee that any online system cannot be breached, thus you are accepting responsibility and risk in allowing Timothy Rogers, MA, LMFT mfc101500 to store your information for therapy session charges

I authorize my therapist, Timothy Rogers, MA, LMFT mfc101500 only to keep my signature and card information on a virtual terminal file that is password protected and HIPAA compliant in order to charge therapy session fees (individual, group, workshops, couples, family or other), and any fees related to therapy related materials (workbooks, DVD's, CD's, and other materials, and/ or fees), or for any appointments with my therapist that are not cancelled 24 hours before the scheduled appointment time to be charged to my credit, charge, or debit card as filled out below for therapy services provided to:

_____ (Therapy Client's Name: Please Print)

I understand that this authorization is valid until canceled in writing. I understand that though this information is secured in an online protected client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I understand that charges for ongoing services or materials will normally be posted to my credit/debit/flex card account within 48 hours of each session date and my session fee will be charged at the start of the day on the day of my session. Additionally, I agree that the card listed below may be charged by my therapist Timothy Rogers, MA, LMFT mfc101500 in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials (i.e. books, CD's, DVD's) that I have not returned within two weeks of completion of my therapy services. I understand that if a chargeback fee is incurred or a retrieval fee is incurred I am responsible for these fees. _____ (Initial here)

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact my therapist for assistance and/or disclosure. I agree

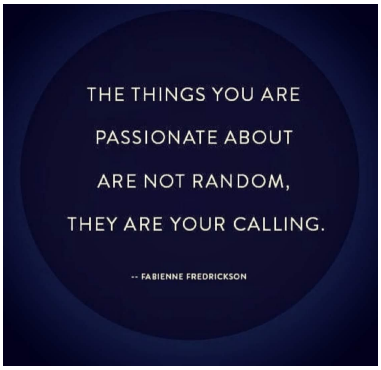
that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with my therapist and those attempts have failed.
_____ (Initial here)
Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by this persons therapist with Self. Centered. Therapy.
_____ (Initial here)
I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Name (print):_____
Signature_____
Relationship to client:_____
Billing Address:_____
Zip Code: _____
Card Type (circle one): 1.Visa 2. MasterCard 3. AmericanExpress
Acct. Number: _____-_____-_____-_____
Exp. Date: _____ zip code _____

3 digit code _____

I understand that my therapy sessions will be charged via this form and not by swiping my card on the morning of my session unless cancelled 24 hours in advance:

Cardholder Signature: _____ Date:



Acknowledgement of Receipt of Privacy Practice Notice

By signing below, I hereby acknowledge receiving and reviewing the Notice of Privacy Practices and Limits of Confidentiality from Timothy Rogers, MA, LMFT of SELF. CENTERED. THERAPY. / Rogers Family Therapy.

_____ _____

Client's Name (print) Date

_____

Client Signature