NEW DIRECTIONS
COUNSELING SERVICES, LLC
WEXFORD • ROBINSON

CREDIT CARD AUTHORIZATION

PLEASE PRINT INFORMATION CLEARLY:

Credit Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date: **Month** ___ ___ **Year** ___ ___ ___ ___

CVV Code (back of card): ___ ___ ___

Type of Card: ❑ **Credit** ❑ **Debit** ❑ **Health Savings/Flexible Spending Account**

Name and Address associated with Card:

_____

_____

_____

_____

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY:

I authorize New Directions Counseling Services, LLC to apply charges to the card listed above under any of the following circumstances:

- At the time of participation in services for the expected amount of an appointment fee to be applied to a health insurance deductible.
- At the time of participation in services for the portion of each appointment fee for which I am responsible including self-pay fees, health insurance copayment amounts and health insurance coinsurance amounts.
- After violation of the practice's cancellation policy requiring payment of a fee for a ***late cancelation or missed appointment*** per the practice's Consent to Treatment and Fee Agreement.

I am aware that New Directions Counseling Services, LLC will be unable to notify me before processing this card on file and that my card may be charged at any time at the discretion of New Directions Counseling Services, LLC for the reasons listed above.

_____ _____ _____

Printed Name of Client **Signature of Client/Legal Guardian** **Date**