Credit Card Authorization Form – Telehealth Services

Ministry of Counseling & Enrichment * 1502 N 1st Street * Abilene, TX 79601

Please complete the following information:

I, _____ **(print name as it appears on the credit card)** authorize First Baptist Mission Action, Inc. to charge my credit card for charges incurred by _____ **(print name of client receiving services).** I understand that per clinic policy, my credit card will be charged in the event of a failure to keep a scheduled appointment with less than 24 business hours notification as agreed to in the Informed Consent. Furthermore, for any outstanding payments of services rendered, I authorize First Baptist Mission Action, Inc. to charge my card for the full amount due.

I will not dispute charges for sessions that have been received or that have not been cancelled within 24 business hours in advance. I further authorize First Baptist Mission Action, Inc. to disclose information about my attendance or cancellation to my credit card company if I dispute a charge.

I understand that there will be a $25 fee for any declined credit card charge.

By signing, I acknowledge that this form serves as prior notice of charges and that I have read, understood, and agreed to the terms above:

Signature: _____ Date:_____

Card Type: (circle one) Visa MasterCard Discover American Express

Full Name on Card:_____

Card #: _____ Expiration Date:_____

3 digit Verification Code:_____

Billing Address for Card:_____
(Street, City, State, and Zip Code)

Signature of Card Holder:_____

**This form is considered protected health information and will be securely stored in your clinical file. The information may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply: no-show for scheduled appointment, cancellation less than 24 business hours in advance, or participation in treatment (e.g. appointment or phone session) without payment rendered.*