Bluffview Counseling
4240 W. Lovers Ln. Dallas, TX 75209

www.bluffviewcounseling.com
Phone: (214) 390-5800

CREDIT CARD AUTHORIZATION FORM

Please note that this form will be securely stored in your clinical file and that you assume the risk for keeping this information on file.

I authorize therapist:

____ Gene Klassen, LPC
____ Jenny Adams, LPC
____ Jon Juhlin, LPC
____ Jackie Ponder Reynolds, LCSW
____ Charlie Fisher, LCSW
____ Missy Desaloms, LCSW
____ Juan Zambrano, LPC
____ Sarah Gammage Ramm, LPCA

doing business as Bluffview Counseling to keep my signature and card information on file and to charge therapy session fees (individual, group, workshops, couples, family or other), Cancelled appointments within 48 hours, and any fees related to therapy related materials (workbooks, DVD's, CD's, and other materials) to be charged to my credit, charge, or debit card or flex spending account as filled out below for therapy services provided to:

_____
(Therapy Client's Name: Please Print)

_____ (*initial*) I understand that this authorization is valid until canceled in writing. I understand that though this information is secured in my 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 on-going services or materials will normally be posted to my credit/debit/flex card account within 72 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 therapist above doing business as Bluffview Counseling in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials [e.g. books, CD's, DVD's] that I have not returned within one week of termination. I understand that if a charge back fee is incurred or a retrieval fee of is incurred I am responsible for these fees.

_____ (*initial*) 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 therapist above 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 therapist above and those attempts have failed.

_____ (*initial*) 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 therapist above.

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Signature: _____

Cardholder Name [print]: _____

Relationship to client: _____

Card Type (circle one): Visa Mastercard AMEX OTHER_____

Acct. Number: _____

Exp. Date: _____

Security Code: _____

Billing Zip 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: _____