Credit Card Payment Authorization

I, _________________________ authorize the following card to be billed:

Check one: ☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

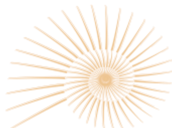
Card Holder's Name: **Card #:**

Expiration: **Security Code:** **Billing Zip Code:**

- I authorize Convergent Mental Health and Wellness, LLC to charge the credit or debit card(s) I provide using Stripe (via Simple Practice) for services rendered. **Initial**
- I also authorize that the provided credit or debit card(s) can be charged (equal to the cost of my scheduled service) if I break the Practice Policies or Appointment and Cancellation Policies that have been provided to me. **Initial**
- I understand my insurance will not pay for late cancellations, missed appointments or fees and I will be responsible for payment. **Initial**
- I understand and agree that the Convergent Mental Health and Wellness will charge my credit card for any outstanding balance past 30 days from date on my invoice. **Initial**
- I understand that if I refuse to leave a valid card on file, I must pay all balances within 30 days, or I will be discharged from Convergent Mental Health and Wellness and I will no longer receive treatment. I also understand that all no-show fees are due the same day or I cannot schedule a new appointment, and any current appointments will be canceled until the fee is paid. **Initial**
- I understand that the Convergent Mental Health and Wellness is not responsible for any security or liability issues with merchant services. I acknowledge that credit card transactions could be linked to Protected Health Information and will appear on bank/credit card statements. **Initial**
- I certify that I am an authorized user of the credit card(s) I've provided (or have permission from the authorized user) and will not dispute these scheduled transactions with the bank or credit card company so long as the transactions correspond to the terms indicated in this authorization form. **Initial**
- I understand that this authorization will remain in effect until I cancel it in writing. **Initial**

I have read this entire agreement and understand that I will be held fully responsible for its terms and charges. I agree that all charges are final and that there are no refunds for services rendered.

Client / Guardian / Representative Signature **Date (MM/DD/YYYY)**



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