

Strategic Therapies and Coaching LLC

Carol Juergensen Sheets LCSW, CSAT, PCC

www.CaroltheCoach.com

(317) 847-2244

Credit Card Authorization Form

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

I authorize Carol Juergensen Sheets LCSW, CSAT, PCC doing business as Strategic Therapies and Coaching LLC, to keep my signature and card information on file, and to charge therapy session fees (individual, group, workshops, couples, family or other), and any fees related to therapy related materials (workbooks, DVDs, CDs, and other materials, and or fees), or for any appointments with therapist Carol Juergensen Sheets that are not canceled 24 hours before the scheduled appointment time 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)

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 ongoing 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 Carol Juergensen Sheets LCSW, CSAT, PCC doing business as Strategic Therapies and Coaching LLC in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services, including any materials (i.e. books, CDs, DVDs) that I have not returned within 1 week of termination. I understand that if a charge back 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 Carol Juergensen Sheets LCSW, CSAT, PCC 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 Carol Juergensen Sheets LCSW, CSAT, PCC. **(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 Carol Juergensen Sheets LCSW, CSAT, PCC. **(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 _____

City, State, Zip Code _____

Card Type (circle one): **VISA** **MasterCard** **American Express** **Discover**

Account Number _____

EXP. Date _____ **3-digit Security 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 canceled 24 hours in advance.

Cardholder Signature _____

Date _____