**Jocelyn Arruda, LMFT  
275 McCorrie Lane, Portsmouth RI 02871 phone: 774-365-8477 \* fax: 401-396-2414**

**Credit Card Authorization Form**

**Any canceled or missed appointments without a 24 hour notice will result in the credit card on file being charged the late cancellation/no show fee of $25.00, as authorized on the Therapy Agreement From.**

**Co-Pays/Co-Insurance**: Co-pays and co-insurances are due at the time of the office visit. You may still choose to make your payment by check, cash, or a card different from the credit card on file.

**Outstanding Balance**: If your insurance provider has paid their portion of your bill and there is still an outstanding balance owed, I will notify you via phone and/or mail. If the balance is not paid in full within 5 days of the notice, at that time, any balance owed will be charged to your credit card. A copy of the charge will be mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company’s determination of payment.

This card will only be authorized for the use of the credit card holder or identified minor client. This agreement will expire upon termination of services and settlement of final balance. The card holder may also revoke this consent at any time in writing while understanding that continued services may not be available if an unpaid balance accrues.

|  |
| --- |
| **Credit Card Information** |
| Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX  □ Other |
| Cardholder Name (as shown on card): |
| Card Number: Security Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Expiration Date (mm/yy): |
| Cardholder ZIP Code (from credit card billing address): |

I, , authorize Jocelyn Arruda, LMFT to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature Date