AUTHORIZATION OF CREDIT CARD PAYMENT OF FEES

I, _____ , authorize the payment of fees for _____
Telephone your name patient's name

to the Twin Cities Cognitive Behavioral Treatment Center, LLC, for services rendered.

BILLING AUTHORIZATION:

I authorize the following charges:

☐ payment of my balance in full

☐ payment of my balance whenever I forget a check or cash payment at time of therapy session

CREDIT CARD INFORMATION:

Name on card

Billing address

City State Zip

Telephone

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card number

Expiration / Security code

Signature: _____ Date: _____

It is the responsibility of the client and the responsible party or parties to notify the billing department at Twin Cities Cognitive Behavioral Treatment Center if the credit card listed on this form is canceled or no longer valid. If there is an issue with the above listed credit card number, the parties listed above will be notified in writing and will have five (5) business days from the date listed on the Twin Cities Cognitive Behavioral Treatment Center's letterhead to provide an updated and valid credit card number to be kept on file.