

**Credit Card Authorization**

(New clients must have credit card on file to receive services at this office.)

This form serves asyour consent to make payment to Sage Tree Psychology Group LLC for individual, family, and/or couples psychotherapy services rendered, as per the attached fee schedule agreement, and your treatment is conditional on your signing this consent form. This form will be securely stored in your clinical file.

**The cancellation policy for services is as follows:**

Sessions must be cancelled at least 24 hours in advance or else you will be charged the full fee for the session. The exception to this is that you will not be charged in the event of an extenuating circumstance (for example, an illness) that necessitates a last-minute cancellation **the first time this happens**. Any future last-minute cancellations will be charged for, no matter the circumstances. Also, any sessions that you do not show up for without notifying me (**“no shows”**) will be charged for in full.

By signing this agreement, you give Sage Psychology Group LLC permission to charge the credit card listed on this form for any cancellation fees assessed as per the above stated agreement.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Sage Tree Psychology Group LLC to bill my credit card at the usual fee for professional services as per the following fee schedule:

Credit Card Type (check one):

\_\_\_\_ Visa \_\_\_\_ MasterCard \_\_\_\_ Discover

Card # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name on card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Verification/Security Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Sage Tree Psychology Group LLC to charge my credit card for

Copayment\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Balance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, I am authorizing Sage Tree Psychology Group LLC to bill my credit card at the usual fee for professional services. I will not dispute charges (“charge back”) for sessions I have received or appointments I have missed according to the above policy.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_