Complete Counseling, 810 Palmer Road, Suite 101-B, Madison, AL 35758 phone 256-213-1934

Credit Card Authorization

. NO SHOW/LATE CANCELLATION FEES
. INSURANCE COPAYS & DEDUCTIBLES
. THERAPY FEES
. TELEHEALTH SESSION CO-PAY AND FEES

In order to provide you and other patients of Complete Counseling with the best possible care, a minimum of 24 hours notice is required to cancel or reschedule your appointments.

I, _____ understand the importance of notifying my therapist at least 24 hours prior to my scheduled appointment that I am not able to keep my appointment. If I am experiencing an emergency, I will provide as much notice as possible to avoid being charged the Late Cancellation fee of $60. I understand that I will be charged a No Show fee of $70 for failing to call and failing to show for my scheduled appointment.

I, _____ give Complete Counseling staff the authorization to charge my credit card $60 for each missed therapy session where 24 hours notice is not given and $70 for each missed therapy session where I fail to call and show for the appointment. These arrangements for payments have been agreed upon in writing between my therapist and me. I will be provided a receipt for all payments upon request. This card may also be used for payment of services upon my request (co-payment, deductibles, and fees).

I understand that I may revoke this agreement at any time by providing a request in writing. I am also aware that when psychological services provided by Complete Counseling staff has ended; this form shall be shredded once I am terminated from treatment.

Name on card: _____

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____

Code: _____ Street Address: _____ Zip Code: _____

Email address for receipt: _____

Patient Name (printed): _____

Patient (or Parent/Guardian)/Card Holder Signature below:

_____ Date: _____