Jamie Kohanyi M.A., MFT
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CREDIT CARD AUTHORIZATION FORM AND CANCELLATION POLICY

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time. This credit card will be charged for therapy sessions unless alternative payment has been presented at the time of services rendered or other arrangements have been made. In case of late cancellations, no shows for scheduled sessions, or if a check is returned unpaid, you will be charged the full session fee of $120. An additional $35 is assessed for returned checks.

I, _____, am authorizing Jamie Kohanyi M.A., MFT to use my credit card information to charge my credit card in the event that I do not notify her by voicemail (not text or email) at least 24 hours in advance of my inability to attend a scheduled therapy appointment or if a check is returned.

Card Type (circle one): Visa MasterCard AMEX

Card #:_____ Expiration Date:_____

Name as Printed on Card:_____

Verification/Security Code (3 digit code on back of card by signature line):_____

Billing Address:_____

City:_____ State: _____ Zip:_____

Signature:_____Date:_____

By signing below, I agree to the cancellation policy and am authorizing **Jamie Kohanyi M.A., MFT** to charge for scheduled appointments which will appear on my statement as Progressive Recovery Counseling Services.

Signature:_____ Date:_____