JAMES A. STAUNTON, MFT
Adult, Child, and Adolescent Psychotherapy
License number: MFT 43811

Credit Card/Debit Card Authorization Form

I am providing my debit or credit card information below for the purpose of paying for my sessions with James Staunton, MFT under the following conditions:

1. My card will be charged after each appointment held, or missed that I do not cancel with 24 hours notice. The charge to you will be the normal fee you or your insurance pays.
2. My card will be charged if a balance accrues due to an unpaid balance from the insurance company, or if a check is returned unpaid. An additional $25 is assessed for returned checks.
3. I am also responsible for any charge back fees if for some reason my credit card is declined. Fees must be paid within 7 days of being notified of such charges and paid by check or cash.
4. I may opt at any appointment to pay copays or other fees by cash or check in lieu of debit or credit card.
5. This authorization becomes a permanent part of my records and will be treated with privacy, confidentiality, and the utmost financial safeguards for the length of time my records are required by law to be retained (up to 7 years).

_____

I, _____ authorize James Staunton, MFT to use my credit card information to charge my credit card in the event that I do not notify Mr. Staunton of my inability to attend a scheduled therapy appointment, do not cancel my appointment at least 24 hours in advance, a check is returned for any reason, or there is any outstanding balance.

Type of Card (circle one): VISA MasterCard Discover Amer. Express

Card Number: _____

Verification/Security Code:_____ Exp. Date: _____/_____

Zip Code:_____

By signing below I am authorizing James Staunton, MFT to charge for scheduled appointments or outstanding balances.

Signature:_____

Date:_____

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