Payment Consent Form

Name _____
Print Name as it appears on your card

Name of client if different: _____

I authorize TriCare Counseling & Consulting, Inc. to charge my credit card for:

Initial

_____ This visit only, for the amount of $ _____

_____ All fees in the next 12 months, beginning _____ /_____ /_____

_____ To charge my card for the balance of fees not paid by my insurance company

_____ I understand the 24 hour cancellation policy and authorize missed appointment fees to be charged to my credit card (required).

Type of Card: 0 Visa 0 MasterCard

Expiration date: _____

Credit Card Number_____ - _____-_____ - _____ CVV Number _____
A 3-digit number in reverse italics on the **back** of the credit card

Card Holder's Billing Address for Credit Card Statements:

_____
Street *City* *State* *Zip*

Email: _____ Phone: _____

Card Holder Signature _____ Date ____ /_____ /____

The date listed on your credit card statement may be different than the actual date of service.

Credit card transactions may appear on your bill as TriCare Counseling & Consulting, Inc.

A receipt for your payment will be emailed to you