



Recurring Payment Authorization Form

To keep client's balances to a minimum, and have our practice run more efficiently, we are requiring a credit card be placed on file. If you choose to pay your balance at the time of service, your card WILL NOT BE CHARGED. However, balances for unpaid sessions, late cancellations, and copays will be charged as they come in, monthly, or on specific days as you outline below. Please note, if you have an FSA or HSA card on file, we will need a back-up card on file in case it is declined. Thank you for your understanding. We appreciate your business and YOU!

I _____ authorize Gonski Counseling Services to charge my credit card indicated below for the amount of \$_____ on the _____ of each _____ for payment of my therapy bill for myself and my dependents listed here:

Billing Address _____ Phone# _____
City, State, Zip _____ Email _____

Credit Card

- Visa MasterCard
- Amex Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV Code _____

SIGNATURE _____

DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Gonski Counseling Services in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.