

Doors of Hope Counseling, LLC
8575 W. 110th St. Suite 218
Overland Park, KS 66210
Credit Card Authorization Form

Your therapist requires a credit card on file. The credit card will be automatically charged at the time of service unless paying with another form of payment. When paying at the time of service, you can pay with cash, check, or card.

Today's Date: ____ - ____ - _____

Your Name: _____

Annual Household Income _____ Number of household members _____

Payment Agreement

I will pay a full or agreed upon amount of my financial responsibility with each visit by cash, check, or card. I understand my credit card will be automatically charged for any balance left. Additionally, I understand that Doors of Hope Counseling, LLC reserves the right to charge the full fee when payments are not made at the time of service. This includes sessions by phone or in person, reports, and/or late cancellation fees.

Credit Card Information and Authorization

Name as it appears on the card: _____

Type of card: Visa Mastercard

Credit card number: ____ - ____ - ____ - ____

Security Code: ____ Expiration Date _____

Street: _____

City: _____ State: _____ Zip code: _____

Phone: _____

I hereby authorize this card to be used for service charges at Doors of Hope Counseling, LLC.

Cardholder signature: _____ Date: _____

Signature

I understand and agree to the terms and conditions on this form.

Patient Signature: _____ **Date:** ____/____/____