

TCC Payment Information

Credit Card Authorization: I, _____ (printed name) authorize the maintenance of valid credit card information to guarantee my chosen payment option. Charges will appear on your credit card statement as "True Connections Counseling."

Cardholder Name: _____

Circle Card Type: Visa MC Discover AmEx

Billing Address: _____ City: _____ Zip: _____

Credit Card # _____ 3 digit CVV code: _____

Expiration date: ____/____/____

Email Address: _____

Cardholder/Client Signature: _____ Date: ____/____/____

Therapist Name: _____

Please check your payment preference:

___ 1. Cash / Check. Pay when services are rendered.

If payment is not made for two consecutive sessions, then your credit card on file will be charged in the amount of the outstanding balance plus a 4% processing fee.

___ 2. Credit Card. Automatic billing (session fee + 1% processing fee)

NOTE: Monthly statements will be provided upon request via email. Clients are responsible for submitting all claims to their insurance provider if your therapist is not on insurance panels.

Payment Guarantee: I understand that I am individually responsible for all incurred charges, even if I direct you to bill another person. If I direct charges to be billed to another person, I represent that I am authorized to give you such direction. If I have directed you to bill charges to another person who fails to make payment promptly when due, I will promptly pay on demand. I understand that if I commit to joining a weekly therapy group, I am responsible for paying for the month of sessions in advance on the first day of the month, regardless of the number of group sessions I attend. I understand that all payments for services are to be made payable directly to True Connections Counseling (TCC), never to the name of the individual therapist. In the event that I dispute a credit card charge without first trying to resolve my concern directly with TCC, I agree to reimburse TCC \$25 per disputed transaction to compensate TCC for the costs incurred in trying to recover disputed funds.

I understand there is a 24-hour cancellation policy and that I will be charged without providing 24 hours advance notice to cancel a session.

I have read, understand and agree to the information, authorization and guarantee stated above.

Signature

Date

Printed Name

Date of Birth