



cohn counseling

Credit Card On File

Please provide credit card information below. By providing this information it will simplify payment procedures in the event of a missed appointment without notice of cancellation, as well as occasions when an appointment is cancelled without 24 hours advanced notice. Credit cards will be charged if there is an unpaid outstanding balance for more than 60 days or an outstanding balance of \$600. Your acceptance of this policy will ensure that your payments will always be up-to-date and will be made in a timely manner. Please note: the use of a credit card will incur a \$5.00 processing fee per session.

Name on card: _____

Billing Address: _____

Visa
 MasterCard
 Discover

Card # _____
Exp. Date _____ Security Code _____

Signature: _____ Date: _____

Your signature authorizes the billing of your card for services. This form will be kept in a secured and locked facility.