K-Counseling & Anxiety Treatment, LLC
Calm mind • Calm body

ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information. Session fees for all clinical treatment will be deducted from the account designated on this form. Forms of payment accepted: Visa, MasterCard, Discover, and Health Savings Account. This document will be securely encrypted with my merchant company and then immediately destroyed via shredding.

Please be aware that all transactions will read ***"Therapy Partner Corporation"*** on your bank or credit card statement. Therapy Partner is the merchant who processes my credit card and e-check transactions. A $30 fee will be assessed for all Charge-backs initiated by any cardholder (charge-backs occur when a cardholder disputes a credit card transaction.)

Monthly Statements: Upon your request, you will receive monthly statements via email for all sessions attended within a calendar month. You may also log into our billing system to generate and print statements for any time period by accessing the following web address: ***www.TherapyPartner.com.*** If you would like access to your account history, please notify me and a username and password will be emailed to you.

CLIENT INFORMATION:

Client Name:_____ DOB: _____

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Responsible Billing Party Name (as displayed on Credit Card/Account):

Billing Address (as registered with Credit Card Company/Bank):

_____

Cell Phone #:_____Home Phone #:_____

Email:_____

FORM OF PAYMENT:

Check One: ☐ Credit ☐ Debit Card

ACCOUNT INFORMATION:

Circle the Card Type (Visa, MasterCard, Health Savings Account or Discover)

Card#: _____CVV#:_____ Exp Date:_____

Client Signature Today's Date