Licensed Clinical Professional Counselor
(773) 905-9805 | JeffreyCiolino@gmail.com | JeffreyCiolinoLCPC.com

Credit Card Authorization

Client's Name ____

By signing below I confirm that I fully understand that health insurance policies and reimbursement issues are between me and my health insurance company, that all services rendered to me are charged directly to me, and that I am solely and personally responsible for payment to Jeffrey J. Ciolino, LCPC and that this responsibility is not related to potential health insurance coverage or reimbursement.

By signing below I authorize Jeffrey J. Ciolino, LCPC to keep my signature and card information on file in order to charge therapy session fees (individual, group, couples, family, telephone consults or telephone sessions), and any fees related to therapy (deductibles, copays, preparation of paperwork for legal, work, or insurance issues above normal billing), or for any appointments with my therapist that are not cancelled 48 hours before the scheduled appointment time to be charged to my credit, charge, or debit card as filled out below.

I understand that this authorization is valid until canceled in writing. I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact my therapist with Jeffrey J. Ciolino, LCPC for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with my therapist and those attempts have failed. Initial _______

Furthermore, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by this individual's therapist at Jeffrey J. Ciolino, LCPC. Initial _____

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

____

CREDIT CARD NUMBER ____________________________________EXPIRATION DATE _______________

3 DIGIT CODE ____________ NAME ON THE CARD ____

ADDRESS THE CARD STATEMENTS ARE MAILED TO (BILLING ADDRESS):

____

SIGNATURE OF CARD HOLDER ____ DATE ______________

Please notify our office as soon as possible if any of this information changes. This agreement will remain in effect, and your card may be charged, until this agreement is cancelled in writing.

Signature ____ Date_______________