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, that I am solely and personally responsible for payment to Jeffrey J. Ciolino, LCPC at the time services are rendered, that there are no refunds, and that payment 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 credit/debit card information on file in order to charge counseling services fees (including but not limited to: individual, group, couples, family, consultation, or telephone interactions), any fees related to counseling (including but not limited to: 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 24 hours before the scheduled appointment time to be charged to my credit/debit card as filled out below. Initial _____

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 Jeffrey J. Ciolino, LCPC for assistance and/or disclosure. I agree that I will not dispute any charges with my credit/debit 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, Jeffrey J. Ciolino, LCPC.

It is your responsibility to notify me as soon as possible if any credit/debit card information changes. This agreement will remain in effect, and your credit/credit card may be charged, until this agreement is cancelled in writing.

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

Signature _____ Date_____

Payment Information

CREDIT CARD NUMBER | | | | | - | | | | | - | | | | | - | | | | |

EXPIRATION DATE | | | / | | | SECURITY CODE | | | |

NAME ON THE CARD _____

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

_____

SIGNATURE OF CARD HOLDER _____ DATE_____