FAMILY COUNSELING CENTER -- ST PETERSBURG

Diane HM Mandell MSSA, LISW, LCSW and Associates

Serving the Community Since 1993

Credit Card Authorization

I, ____________________________ (print name) am authorizing Family Counseling Center, Diane Miller-Mandell & Associates, to charge my credit card in the event that I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment at least 24 business hours in advance, as agreed to in the Office Policy Form. Furthermore, for outstanding payments of services rendered, I authorize Family Counseling Center, Diane Miller-Mandell & Associates to charge my credit card for the full amount due. I will not dispute for sessions I have received or that I have not cancelled less than 24 business hours in advance.

I further authorize Family Counseling Center, Diane Miller-Mandell & Associates, to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

Card Type (circle one): Visa Mastercard American Express

Card #: ____

3-digit Security Code (4-digit for American Express): _____________

Expiration date: ________________

Name as printed on card: ____

Billing Address: ____
(Street, City, State, & Zip)

Signature: _______________________________________ Date: _____________________
(patient or financially responsible party)

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply:

- No-show for a schedule appointment
- Cancellation less than 24 business hours in advance
- Participation in treatment (eg. Appointment or phone session) without payment rendered