Counseling Connections of San Antonio
7400 Blanco Rd, Ste 250
San Antonio, TX 78216

Authorization to Secure Payment

I, _____ authorize *Counseling Connections of San Antonio* to process payment on my **Visa or MasterCard or Discover card or American Express (if applicable)** for any balance due that has not been paid **10 business days after it is received.**

I understand that if the appointment is missed and do not follow the cancellation policy as specified, *Counseling Connections of San Antonio* is authorized to charge my credit card the same as the missed appointment.

I understand that if my card is declined, *Counseling Connections of San Antonio* may put my **Visa or MasterCard or Discover card or American Express (if applicable)** payment through on another day when funds become available.

I understand that I have given *Counseling Connections of San Antonio* my **Visa or MasterCard or Discover card or American Express (if applicable)** *(circle applicable)* information. I further understand that if I miss a scheduled appointment or fail to provide 24 hours notice (regardless of reason), my credit card will be charged the full amount of the session.

I have read and understand this form. I attest that the information below is true and accurate.

My credit card information will be scanned into a SECURE HIPAA patient record and held to the privacy laws in the state in which services are rendered.

_____ _____

Signature of Card Holder Today's Date

Your signature above acknowledges your session Co-Insurance, Deductible, or Patient Responsibility will automatically be charged to your Credit card.

E-Mail Address_____

*Note: Please provide an email address if you would like a statement and/or explanation of benefits emailed to you in an **encrypted** manner and/or utilize our NEW Patient Ally systems (please inquire with your counselor or office staff).*

**The above mentioned charges on your card will appear from Counseling Connections of San Antonio.