** Disregard this form if no fee is due at time of service**

Payment Authorization Agreement

Sign and complete this form to authorize The Samaritan Counseling Center, Inc. to securely store payment information to facilitate the payment of session fees. The full credit card number is NOT visible to Center personnel and clinicians and is NOT stored in the Center's office.

Please do not write down or e-mail your payment information to the Center. If this authorization is on file at your next session, when the front office or clinician takes payment information, he or she can store the information on your behalf.

I am aware that if any of my personal information changes, I am responsible to notify The Samaritan Counseling Center of the change(s) to ensure they have the most current information to contact me or process payment accurately.

Authorization Agreement

By signing below, I authorize The Samaritan Counseling Center front office personnel or clinician to obtain my credit/debit/health savings account information in person, by phone or through the video-therapy platform; and to securely store my payment information on a remote server for session fees.

Client Name:_____

Name of Cardholder (if different from Client):_____

Signature of Cardholder:_____

Date of Signature:_____

****This authorization may be withdrawn at any time at the discretion of the client or Center****