Into the Light
Mental Health and Consulting Services, Inc.
201 NW 4th St. Suite 105
Evansville, IN 47708
812-454-1564
Laura Symon, MSW, LCSW, CSAT, SEP

Client Credit Card Authorization Form

_____ *I authorize my therapist with Into The Light Mental Health and Consulting Services, Inc. to keep my signature and card information on a virtual terminal file that is password protected and HIPAA compliant in order to charge therapy sessions, phone sessions or for any appointments with my therapist that are not cancelled 24 hours before the scheduled appointment time, or for outstanding balances and collections fees.

_____ *I understand that this authorization is valid unless cancelled in writing. I understand that though this information is secured in an online protected client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised.

_____ *I understand that if I am assuming session payment responsibility for the client listed below, 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 person's therapist at Into The Light Mental Health and Consulting Services, Inc. unless the client signs a Release of Information.

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

Client's Name*: _____

Cardholder Name and Relationship to Client*:_____

Address Including Zip Code*: _____

Phone Number*: _____

Card Number*: _____-_____-_____-_____ Exp. Date*: _____ 3 Digit Code*:_____

Cardholder Signature*: _____ Date*: _____

Client Signature*: _____ Date*: _____