Institute for Couple and Family Enhancement
PRE-AUTHORIZED BILLING AGREEMENT

I authorize my therapist named below to keep my credit card information and signature on file. <u>Charges will only be made to my card for the following reasons:</u>

- Appointments attended- I may request for my card to be charged after each appointment to save time at the end of each session.
- Returned checks- I understand that my card will be charged for any outstanding balance on my account plus a $30 administrative fee for returned checks.
- Charges for missed appointments- I understand that my therapist has a 24-hour cancellation policy and my card will be billed for the full amount of any session if I do not attend a schedule session that is not cancelled or rescheduled at least 24 hours prior to the scheduled time and day.

I understand that my credit card information will be destroyed 60 days after the last session that I attend with my therapist, in compliance with Texas law. I may revoke this agreement at any time by providing a request in writing.

ICFE Therapist ____

Client Name ____

Card holder's Name ____

Card holder's Address ____

City ______________________ State _________ Zip __________________

- ❑ Visa — Security code (on back) _________
- ❑ Discover — Security code (on back) _________
- ❑ Mastercard — Security code (on back) _________
- ❑ American Express — Security code (on back) _________

Credit Card Number ____

Expiration Date ________________________

Signature below acknowledges client agreement with terms above, and agreement to pay total balance according to the card issuer agreement. My signature also serves to attest to the accuracy of the above billing information, including card holder identity.

Signature ____