



89 MCCRORY DRIVE
PO Box 856
CAMDENTON, MO 65020
573-525-7071 P
573-525-7072 F

119 N BENTON ST
PO Box 514
WAYNESVILLE, MO 65583
573-433-2833 P
573-433-2829 F

1030 KINGSHIGHWAY
SUITE A
ROLLA, MO 65402
573-458-9920 P

CREDIT CARD AUTHORIZATION FORM

I, _____ authorize Benton Street Counseling, LLC. to charge my credit/debit card for the following:

(Initial all that apply)

- \$_____ for all individual, couples, or family counseling/consultation sessions
- Copay or coinsurance rate for all attended appointments
- \$_____ for any appointment missed or canceled with less than 24 hours' notice
- Any portion of billable services not covered by my insurance policy
- \$_____ of my balance due on the _____(date) of each month beginning on _____ until my balance is paid in full
- Other: _____

Name Printed on Card: _____ Type of Card: _____

Credit Card Number: _____ Expiration Date: _____

CVC 3- or 4-Digit Code: _____ Billing Address Zip Code: _____

By signing below, I certify that the above information is true and accurate and that I am an authorized user on the credit card/debit account above. I authorize Benton Street Counseling, LLC. to keep my credit card information on file and charge the above fees automatically and on an ongoing basis until or unless I cancel these automatic payments in writing. I understand that I am responsible for notifying Benton Street Counseling, LLC. if my credit/debit card information needs to be updated. Benton Street Counseling, LLC. agrees to ONLY charge for services rendered or for appointments not cancelled 24 hours in advance. I understand that if I wish to cancel an appointment I will need to speak with an associate of Benton Street Counseling, LLC, send an email to the correct email address of my therapist, or leave a recorded voicemail message at (573) 433-2833.

Client Signature: _____

Date: _____