CENTRAL FOCUS
PSYCHOLOGICAL GROUP

1259 Lake Plaza Dr, Suite 255 P: (719) 598-3585/F: (720) 358-2674
Colorado Springs, CO 80906 www.centralfocusgroup.com

Client Credit Card Authorization Form

Please note that the information on this form will be securely entered and stored in a HIPAA compliant online virtual terminal that is password protected for your safety. Once your information has been entered by your clinician to the secured terminal, these paper forms will be shredded and destroyed immediately to protect your information. While all secure methods to protect your information are in place, and we take your safety seriously, no company can 100% guarantee that any online system cannot be breached, thus you are accepting responsibility and risk in allowing Pickett Psychological Services, LLC, doing business as Central Focus Psychological Group, to store your information for therapy charges.

I authorize *Central Focus Psychological Group (Pickett Psychological Services, LLC)* to keep my signature and card information on a virtual terminal file that is password protected and HIPAA compliant in order to charge treatment and session fees (therapy, psychiatric/medication management, diagnostic evaluation) or any appointments that are not canceled **48 hours** before the scheduled appointment time to my credit, charge, or debit card as filled out below for services provided to:

_____
(Client's Name: Please Print)

Cancellation/No Show Fees: Therapy: **$100 fee**, Psychiatric/medication management $**100 fee**, Diagnostic evaluation **$500 fee**._____(Initial here)

I understand that this authorization is valid until canceled 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 charges for ongoing services will normally be posted to my credit/debit/flex card account within 24 hours before each session date and **my session fee will be charged within 24 hours prior to my session.**

Additionally, I agree that the card listed below may be charged by *Central Focus Psychological Group (Pickett Psychological Services, LLC)* in order to settle any outstanding balances accrued by the above listed client upon termination of services within one week of completion of services. I understand that if a charge back fee is incurred or a retrieval fee of is incurred, I am responsible for these fees. _____ (Initial here)

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact *Central Focus Psychological Group (Pickett Psychological Services, LLC)* for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with *Central Focus Psychological Group (Pickett Psychological Services, LLC)* and those attempts have failed. _____ (Initial here)

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Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential sessions unless the client is considered a minor and/or I possess legal guardianship of the client at *Central Focus Psychological Group (Pickett Psychological Services, LLC)*. _____ (Initial here)

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

Cardholder Name (print): _____

Signature_____

Relationship to client: _____

Billing Address: _____

Zip Code: _____

Card Type (**circle one):** 1. Visa 2. Mastercard (Note: CFPG does not accept AMEX)

Acct. Number: _____-_____-_____-_____

Exp. Date: _____

I understand that my sessions will be charged via this form, and not by swiping my card, within 24 before my session unless cancelled 72 hours in advance:

Cardholder Signature: _____ Date: _____