Credit Card Authorization

CG Therapies provides secured methods of accepting your payment at the time of service and for keeping your credit card on file.

I, (Card Holder or Authorized User) _____, authorize CG Therapies to maintain the credit card information and signature on file listed below, for charges, including copayments, deductibles, or coinsurance responsibilities, late cancellation fee charges as determined, and any outstanding balances for services unpaid.

I also attest that the information listed below is my personal information or I have obtained and have full authorization and permission to utilize it. If the card listed below is not my personal card, I accept all responsibility for payment and liability regarding any CG Therapies' charges that are disputed by the actual card holder.

I authorize CG Therapies to issue me receipt of payment via electronic mail. I understand that receipts from CG Therapies indicate that I am participating in mental health treatment services and I authorize the transmission of this information to the email address list below:

E-mail: _____

Client Name: _____

Card Holder Name: _____

Type of Credit Card: Mastercard Visa American Express Other:_____

Credit Card #: _____

Billing Address: _____

Billing City, State: _____ , _____ Billing Zip Code: _____

Expiration Date: _____/_____ Security Code: _____

Card Holder Signature: _____ Date: _____

Witness: _____ Date: _____