Front Range Psychological Services
5738 Olde Wadsworth Blvd.
Arvada, CO 80002
Ph. 720-230-6863

Informed Consent for Credit Card Billing

I, _____, authorize Front Range Psychological Services to keep my signature and card information in secure storage system in order to charge therapy fees (e.g. individual, group, couples, family, etc.), or for any appointments which are cancelled with less than 48 hour notice.

I understand that this authorization is valid until canceled in writing. I understand that though this information is secured in a locked 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 account within 48 hours of each session. Additionally, I agree that the card listed below may be charged by Front Range Psychological Services in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services. I understand that if a chargeback fee or a retrieval fee 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 Front Range Psychological Services 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 Front Range Psychological Services and those attempts have failed. _____ (Initial here)

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

_____ _____/_____/_____
Client Signature Date

Credit Card Information:
Cardholder Name (print):_____

Signature_____

Billing Address:_____

Zip Code: _____

Card Type (circle one): Visa MasterCard AMEX Discover

Card Number: _____

CVC Number: _____ Exp. Date: _____