THE CENTER FOR PSYCHOTHERAPY, INC.
At ● Essex ● Guilford ● Old Lyme

Serving the mental health needs of the Shoreline communities
Central Office: 28 Main Street, Essex, CT 06426 ● Ph (860) 767-1517 ● Fax (860) 767-7703

Credit Card Authorization Agreement

I, _____, authorize The Center for Psychotherapy, Inc. to charge my VISA/MasterCard (*circle one)*, account number _____, expiration date _____, to pay balances over $150 and/or over 60 days overdue. Alternatively and if desired, I authorize a one-time payment of $_____ to pay the remaining overdue balance on my account. The name and billing address for this credit card is:

Cardholder Name: _____

Street Address:_____

City, State, Zip:_____

I understand that these balances may include charges for missed visits ("no-shows") and for late cancellations, which insurance companies do not cover. I understand that I will be held responsible for any charges or fees if authorization is declined.

I will advise you immediately if I close this account. I understand that The Center for Psychotherapy, Inc. is relying on this information in continuing to provide services to me.

I understand that, after a notification is includes with my monthly billing statement, I will have seven (7) days to mail my payment or the above-listed credit card will be charge in 14 days.

_____ _____

Signature *Patient* Name if other than cardholder

Clinician's Initials:_____