Youth, & Family Counseling Services

Heartprints
Kristal Mathis, LMHC, CMHS
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Vancouver, WA 98661
www.kristalmathis.com

Credit Card Authorization

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at anytime.

I, _______________, authorize Kristal Mathis, Licensed Mental Health Counselor, to charge my credit card for professional services as follows:

Please Initial:
____ Recurring charges for services in the amount of $155 (or other______) per visit.

____ I understand and agree that my card will be charged Heartprints' full fee for cancellations with less than 24 hours notice and for appointments I miss without notice as agreed in the Counselor Disclosure Form I signed.

____ I understand and agree that my card will be charged for balances of charges not paid by me or my insurance (such as deductibles and co-pays).

____ I understand this form is valid unless I cancel the authorization in writing. I will not dispute the charges ("charge back") for session I have received of appointments I missed according to the above policy.

____I understand and agree my card will be charged $265 for the initial intake.

Charges will appear on your credit card statement as "Heartprints"
Visa MasterCard Debit Card

Card # ___________________________________

Expiration Date:______________ Verification/Security Code:______
Name as printed on card:
____
Billing Address (Street, City, State, & Zip Code):
____

Print Name____

Signature: ____Date:__________________________