BestPractice
PSYCHOTHERAPY
— HELPING YOU MAINTAIN A HEALTHY SELF —

Preauthorization for Health Care Payments

I authorize **Best Practice Psychotherapy, LLC** to keep my signature on file and to charge my credit/debit card for:

- Fee of $95.00 charged for missed appointments or cancellations with less than 24 hours notification as stated in the signed Payment Contract for Service. *This applies to private pay and commercial insurance clients only

- All balances not paid by insurance or other 3rd party payers after 60 days.

- Recurring charges (on going treatment) as per amounts stated in the signed Payment Contract with the practice. *This applies only to private pay clients

I understand that this form is valid for one year unless I cancel the authorization through written notice to this practice.

Client's Name:____

Cardholder's Name:____

Cardholder's Billing Address:____

City______________________State ___________Zip:_____________

Charge Card Number:______________________Expiration Date: Month____Year____CVV____

Cardholder's Signature:____________________________________Date:__________________