2700 South Roan Street, Suite 435 Johnson City, TN 37601   P: 423.408.8041
support@journeycentercounseling.com

Credit Card Authorization

I authorize The Journey Center for Healing Arts, PLLC to keep my signature on file and charge my credit card account for:

- Charges for services rendered, at the time of service, including copays, coinsurance, out of pocket fees, deductibles, no show, and late cancel fees
- Charges for missed appointments ($65, if cancelled less than 36hrs ahead)
- Balances of charges not paid by me within 30 days, or insurance within 60 days

Cardholder's Name ____

Cardholder's Address ____

City _________________________________ State _____ Zip _____________

- ❑ VISA
- ❑ Master Card
- ❑ Discover
- ❑ American Express

Account number ____

Expiration date ___________________ Security Code __________________

Card Holder Signature ____

The Journey Center for Healing Arts, PLLC will store your credit card information in a HIAPP compliant electronic health system.

I understand that I may revoke this agreement at any time by providing a request in writing.

I have read, I understand, and agree to the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

____

Printed Name of Client   Signature of Client   Date

____

Printed Name of Legal Guardian   Signature of Legal Guardian   Date

Relationship to client: ___________________________

Client: **Date of Birth:**