Payment Preauthorization Agreement

Kaitlin Jones, LMFT
2625 Redwing Road, Suite 175
Fort Collins, CO 80526
(970) 613-1315

I authorize Kaitlin Jones to keep my signature on file and to charge fees, or partial fees, to my credit or debit card account for services provided to _____.
Client Name (Please Print)

I understand that this authorization is valid until cancelled in writing. I understand that charges for ongoing services will normally be posted to my credit card account within 48 hours of each service date. Additionally, I agree that the card listed below may be charged by Kaitlin Jones in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services. I agree that I will contact Kaitlin Jones if I have any problems or questions regarding charges to my account. 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 Kaitlin Jones and those attempts have failed.

Credit or Debit Card Information	
Cardholder Name:	
Billing Street Address:	
City:	
State:	
Zip Code:	
Card Type:	☐ Debit ☐ Credit ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express
Account Number:	
Expiration Date: (Month & Year)	
Card Security Code: (3 or 4 digit number on the back of your card by your signature)	

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above.

Cardholder Signature: _____ Date: _____