THE MARIPOSA CENTER LLC
FOR INFANT, CHILD & FAMILY ENRICHMENT

Credit/Debit Card Payment Consent Form

Please re-check your information. Giving incorrect credit/debit card information is considered fraud. Your therapist at The Mariposa Center requests that you provide your credit card information below. If you choose to pay by credit card, your card will be charged $_____ after each traditional session or as outlined in The Mariposa Center's Policy Agreement. If you choose to pay by cash or check, your credit card will only be charged if your account is past due and/or for any additional fees you and/or your minor child/ren incur such as late cancellation or no-show fees.

Client Name: _____

Cardholder Name (if different from client): _____

I, _____(Cardholder Name), authorize Emily McNeil, LPC, BC-DMT, EMDR-Cert./ Jennifer Platt, LPC, R-DMT-EMDR-Cert./ Megan Hall, LPC, R-DMT/Dafnah Meron LCSW/The Mariposa Center for Infant, Child, and Family Enrichment/Colorado Medical Billing, LLC (Medical Billing Service) (hereinafter collectively known as "The Mariposa Center") to charge my card for professional services, NO SHOWS, failure to give 24 hours cancellation notification, and/or co-payments, deductibles, co-insurance and any other payments not covered by my insurance carrier that is my financial responsibility as the responsible party for the above referenced client account.

Type of card: _____ Visa _____ MasterCard _____ Discover _____ AMEX _____ FSA/HSA Medical Card (you may only use this card for co-payments, all other charge must be applied to another credit/debit card)

Cr/Debit Card #: _____ - _____ - _____- _____ CVV Number: _____ Expiration Date_____
FSA/HSA Card #: _____ - _____ - _____- _____ CVV Number: _____ Expiration Date_____
Name on Card:_____
Billing Address, including zip code (where card statement is sent):
_____
_____

If I have question about these charges, I agree to contact my therapist and, if necessary, Jessica Dennis of Colorado Medical Billing, LLC, via email at comedbill@gmail.com. I agree that I will not pursue a refund/credit directly through my credit or debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

By signing this authorization form, I agree to notify The Mariposa Center of any changes to my credit card information such as a new expiration date or when my credit card has been cancelled, lost, stolen, or revoked. A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended.

This credit card authorization form with remain in effect and on file at The Mariposa Center unless revoked in writing or until the therapeutic relationship is terminated, at which time, authorization to charge your credit card will be revoked unless an outstanding balance remains on your account after termination. The Mariposa Center will not share your credit card information with any third-party payor without client consent. Your credit card information will be kept confidential.

If cardholder is a third-party payor:

I_____, hereby authorize The Mariposa Center to charge the above bank credit card for payment of the counseling fees (client)_____ incurs; which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my card will be billed in accordance with the authorizations listed above. I agree to notify The Mariposa Center of any changes to my credit card information including a new expiration date or when my credit card has been cancelled, lost, stolen, or revoked. I understand as a third-party payor that I am only entitled to receive information concerning payment and that this Credit Card Authorization Form does not authorize me to receive any confidential and protected information about the client beyond payment.

Third-Party Payor's Signature:_____

Date:_____

I_____, authorize The Mariposa Center to communicate with the above third-party payor solely as it may relate to payment for services I receive at The Mariposa Center.

Client/Parent/Legal Guardian Signature:_____

Date:_____

If cardholder is client/parent/legal guardian:

I_____, hereby authorize The Mariposa Center to charge the above bank credit card for payment of the counseling fees I or my minor child/ren incur; which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my card will be charged in accordance with the authorizations listed above. I agree to notify The Mariposa Center of any changes to my credit card information including a new expiration date or when my credit card has been cancelled, lost, stolen, or revoked.

Client/Parent/Legal Guardian/Cardholder Signature:_____

Date:_____

Charges will read as one of the following: Emily McNeil, LPC, BC-DMT, EMDR-Cert. / Jennifer Platt, LPC, R-DMT EMDR-Cert./ Megan Hall, LPC, R-DMT/Dafnah Meron, LCSW/The Mariposa Center for Infant, Child & Family Enrichment/Colorado Medical Billing, LLC.