Crossroads Counseling Services
Prompt, Professional, Courteous

- Individual & Family Therapy
- Substance Abuse Treatment
- Medication Management Treatment

Payment Guarantee + Agreement to Pay

We ask all clients to keep a current credit card on file. By providing your credit card information below, you authorize us to charge unpaid balances and fees of any kind to this card. The most common charges include the cost of professional services and cancellation fees. We will save this credit card information in your file for future charges. You also agree to pay all costs you incur for our services that are not paid by your insurance.

After insurance has processed your claim, we will charge this card for all remaining balances that are less than $250. For amounts over $250, prior to charging your card, we will notify you by phone. If we cannot reach you, we will leave a voicemail and charge this card.

Name on Card _____ Phone Number _____ Email _____

Card Number _____ Expiration Date _____ Security Code _____

Relation to the client: ❒ Client's card | ❒ Describe: _____

❒ Visa | ❒ Mastercard | ❒ AMEX | ❒ Discover | ❒ Other: _____

Card billing address: Street Address _____ City _____ State _____ Zip _____

You authorize all recurring charges for the follow individuals to be charged to your card.

Client name _____ Date of birth _____

Client name _____ Date of birth _____

Client name _____ Date of birth _____

You may terminate this authorization at any time. But any unpaid amounts will first be charged to this card. Accordingly, you, the cardholder, hereby authorizes the above credit card to be charged for agreed purchases or services, including cancellation, or returned check charges, and to be saved to our file.

Cardholder Signature _____ **Date** _____