Be the author of your story...

Emergent Pathways Psychotherapy

www.emergepsych.com | 346.232.5060

Credit Card Authorization Form

At **Emergent Pathways Psychotherapy** we use an app called Venmo to collect payments. You have to download the app and make an account to send money to Dr. Stanley for your visit on the day of your appointment. If you plan on using Venmo, you have to connect your bank account or debit card to send money. Dr. Stanley's username is **Ks Stanley@Ks-Stanley** on Venmo. We also use PayPal. You can find Dr. Stanley by searching this e-mail address: **kstanleypsyd@outlook.com .**

If you are paying with a credit card we charge a processing fee that is a percentage of the payment. We require keeping your credit card on file as a convenient method of payment for your patient responsibility that is due at the time of service. It also will be used in the event of a late cancellation or no show. Your credit card information is kept confidential and secure and payments to your card are processed on the date of your appointment with Dr. Stanley by the end of the business day.

I authorize **Emergent Pathways Psychotherapy** to charge the portion of my bill that is my financial responsibility to the following credit card:

Please fill in which payment method you will be using:

Venmo(only if paying with debit cards and bank accounts, no processing charge)

Venmo Username _____

Credit Card(only if paying with a credit card, $5 processing fee)

Cardholder Name _____

Credit Card # _____-_____-_____-_____ *Expiration Date* _____ /_____

*Security Code*_____ *AMEX Code*_____ *Zip* _____

I , _____, authorize **Emergent Pathways Psychotherapy** to charge my credit card, indicated above, for balances due for services rendered that my insurance company identified as my financial responsibility (copay/coinsurance, deductible, or agreed upon cash rate-if you pay out of pocket, No show/Cancellation < 24 hours before your scheduled

appointment fee). This authorization relates to all payments not covered by my insurance company for services provided to me by **Emergent Pathways Psychotherapy**.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 30 day notification to **Emergent Pathways Psychotherapy** in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date:_____