



Authorization to Keep Credit/Debit Card Information on File

At Groupworks, we require keeping your credit or debit card on file as a convenient method of payment for services.

Your credit card information is kept confidential and secure and payments to your card are processed:

- (1) on a weekly basis with Group Therapy (only when the child is present)
- (2) at the time of service with Individual & Family Therapy

I authorize Groupworks to charge services to the following credit or debit card:

Amex Visa Mastercard Discover

Credit Card Number _____
Expiration Date(MM/YY) ____ / ____ CVV Code _____
Cardholder Name _____
Signature _____
Billing Address _____
City _____ State _____ Zip _____

I (we), the undersigned, authorize and request Groupworks to charge my credit card, indicated above, for balances due for services rendered.

This authorization relates to all payments for services provided to me/my child by Groupworks.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 30 day notification to Groupworks in writing and the account must be in good standing. I understand that any amount owed at the time of cancellation will be charged to this account.

Patient Name (Print): _____

Signature of Responsible Party: _____

Responsible Party Name (If Different from Patient-Print) _____

Date: ____ / ____ / ____