CHRISTIAN COUNSELING ASSOCIATES

of Western Pennsylvania

Credit Card Processing Authorization Form

Patient Name: _____

Cardholder Name (as appears on card): _____

Cardholder's Email: _____

Credit Card Info: ◯ Visa ◯ Mastercard ◯ Discover ◯ HSA Account

Credit Card Number: _____

Exp Date: _____ **Is this a Debit Card?** ◯ **Yes** ◯ **No**

Security Code (Three digit number on back of card): _____

Statement of Authorization:

My signature authorizes Christian Counseling Associates (CCA) to keep credit card information on file and to bill all charges associated with my counseling services to my credit card account. These charges will be made automatically on a 2 week billing cycle as long as this agreement remains valid. Any charge being made to my account will be followed by an e-mail confirmation of the charged being made.

- **I understand that I may revoke this agreement at any time by verbal or written notification to my CCA Counselor.**

I understand that I am responsible for any overdraft fee or other surcharge associated with my debit or credit card account. All amounts due to CCA, including deductible amounts, co-payments due, or late cancellation fees are non-refundable. Although unlikely, if a CCA billing error is made, a full refund will be made upon request to my CCA counselor. At my official completion of treatment, this credit card agreement will become void.

I agree to notify CCA if my credit information changes, and will take responsibility for any surcharge that is incurred by a voided transaction caused by incorrect credit card information.

Signature: _____ Date: _____

Counselor Name (Please Print): _____

101 Pembroke Ct., Greensburg PA 15601

724-396-1510 724-691-0476 CCAWPA.com CCAWPA@gmail.com CCAWPA