

**Pathfinders Counseling, PLLC  
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420 S. Howes Street, #B100  
Fort Collins, CO 80521**

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www.pathfinderscounselingllc.com**

**CREDIT CARD AUTHORIZATION FORM**

Pathfinders Counseling, PLLC requests that you provide your credit card information below. If you choose to pay by credit card your credit card will be charged \$\_\_\_\_\_ after each session on the day the session occurs. 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-shows fees.

I do not authorize Pathfinders Counseling, PLLC to charge my credit card after each session but only for additional fees I and/or my minor child/ren incur as set forth in Pathfinders Counseling, PLLC disclosure statement and policies. I will be notified of the type of additional fees I and/or my minor child/ren incur.

I authorize Pathfinders Counseling, PLLC to charge my credit card \$\_\_\_\_\_ after each session and for any and all additional fees I and/or my minor child/ren incur.

If your credit card does not go through, you do not have a credit card, or you do not wish to provide your credit card information, in the event your account remains past due for sixty (60) days, your account may be sent to collections. Pathfinders Counseling, PLLC reserves the right to send your account to collections, in accordance with Pathfinders Counseling, PLLC policies and procedures; at any time after your account is considered past due.

By signing this authorization form, you agree to notify Pathfinders Counseling, PLLC of any changes to your credit card information such as a new expiration date or when your 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.

**PATHFINDERS COUNSELING, PLLC  
ONLY ACCEPTS THE FOLLOWING CREDIT CARDS:**

**VISA**       **DISCOVER**       **AMERICAN EXPRESS**       **MASTERCARD**

Name on Credit Card: \_\_\_\_\_

Type of Credit Card: Visa \_\_\_ MasterCard \_\_\_ Discover \_\_\_ American Express \_\_\_

Credit Card Number \_\_\_\_\_

CCV Code: \_\_\_\_\_

Expiration Date : \_\_\_\_\_

Card Holder's Full Address, including zip code (the mailing address for your Credit Card statements):

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This credit card authorization form will remain in effect and on file at Pathfinders Counseling, PLLC 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. Pathfinders Counseling, PLLC will not share your credit card information with any third-party without your consent. Your credit card information will be kept confidential.

Please check one:

Card Holder is the client (or parent/legal guardian) receiving services from Pathfinders Counseling, PLLC.

I hereby authorize Pathfinders Counseling, PLLC to charge the above credit card number for payment of the counseling fees I or my minor child/ren incurs, which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above.

\_\_\_\_\_  
Client/Parent/Legal Guardian Signature

\_\_\_\_\_  
DATE

Card Holder is a third-party payer for the client receiving services from Pathfinders Counseling, PLLC.

I \_\_\_\_\_, hereby authorize Pathfinders Counseling, PLLC to charge the above credit card number 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 credit card will be billed in accordance with the authorizations listed above. I understand as a third-party payer 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 Client beyond payment.

\_\_\_\_\_  
Third-Party Payer's Signature

\_\_\_\_\_  
DATE

I, \_\_\_\_\_, authorize Pathfinders Counseling, PLLC to communicate with the above Third-Party Payer solely as it may relate to payment for services I receive from Pathfinders Counseling, PLLC.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
DATE