Beacon
THERAPY ASSOCIATES, P.C.
Inspiring personal growth through insight

e-Payment Standing Authorization

Name: _____ Account: _____

(Please print) (Office use)

I, the undersigned, authorize my therapist and/or Beacon Therapy Associates, P.C. to initiate electronic debit entries to my Debit Card or Credit Card for the balance of charges not paid by insurance. This authority will remain in effect until I have cancelled it in writing.

I further understand and agree that if any payments to Beacon Therapy Associates are dishonored or returned, there will be a return fee of $30.00, and interest will be assessed at a rate of 1.5% per month on any past due balances over 30 days. I also understand and agree that if I am in default of this agreement, I will pay all reasonable legal fees, court costs and cost necessary to collect debt, including fees charged by a collection agency.

Signature: _____ Date: _____

Email: _____

(Needed to send receipt)

This authorization covers all family members associated with this account. Please list any family members that you would like to *exclude* from this authorization:

_____

Debit Card or Credit

Type of Card: □Visa □Master Card □Discover Card □American Express (Choose one)

Cardholder Name: _____ (as it appears on the card)

(Please print)

Card Number: _____

Exp. Date: _____ CVV: _____ Billing Zip Code: _____

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