Payment Policy/ Credit Card Authorization Form

Irenic Counseling
Michael Miller, MA, LMFT
27001 La Paz Rd., Suite 300B-3
Mission Viejo, CA 92691

I ______________________________________, hereby authorize Michael Miller to keep my signature on file in order to secure my initial appointment and/or charge fees, or partial fees, to my credit or debit card account for services provided by Michael Miller, M.A. to ___________________ (patient's name) as detailed below:

Fees Clients seen by Michael Miller, M.A. agree to pay $150 per 50-minute session, $225 per 80-minute session. This fee was agreed upon prior to beginning psychotherapy. Any services beyond these standard sessions, such as phone consultation exceeding 15 minutes or excessive paperwork for reports will incur additional fees to be discussed prior to service being provided. If you do not show or fail to cancel your appointment 24-hour in advance, a fee of $125 will be charged to your card.

Cash, checks and credit cards will be accepted as forms of payment. Please note that there is a $25 fee for returned checks. Should you miss a payment, for whatever reason, therapy sessions may be postponed until the full payment is rendered. **You are responsible for the full payment at the time service is provided.** I understand that fees will be charged to my credit or debit card on the same day that charges are incurred or by the end of the week. If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will provide you with any options that may be available to you at that time.

I agree that:

In the event my card becomes invalid I will provide Michael Miller M.A. with a new duly executed credit or debit card authorization form.

This authorization is valid until cancelled in writing via email at michael@ireniccounseling.com or by mail at the above address.

If I have any questions or problems regarding the charges to my account, I will contact Michael Miller, M.A. for assistance. I agree that I will not dispute any legitimate charges processed by Michael Miller M.A..

This information is kept in a confidential file that is **locked at all times**.

Card type (circle) MC Visa

Patient's Name ____

Name on Card_________________________ CC number__________________________

Exp Date___/_____/_____ CVC code (on back of card)_____________

Address on file for card____

City_______________________________________State_______Zip________________

I have read, understand and agree to the above fee payment and credit card policy for services provided by Michael Miller, M.A. LMFT Lic # LMFT92104

Signature____Date____________________