



Wellness Counseling & Therapy Services
 Don't Let Your Mind Be An Obstacle

www.wellnesscounselingclinic.com
 Phone: 630-214-4000
 Email: info@wellnesscounselingclinic.com

Date: ____/____/____

CREDIT CARD AUTHORIZATION

The undersigned agrees and authorizes Wellness Counseling, Inc. c/o Nabeela Choudry, LCPC to charge the credit card indicated below for any account balances which include, but are not limited to, deductible, co-pay, coinsurance, and fees for late cancel and no-show appointments.

Client's Name: _____

Name as it Appears on the Credit Card: _____

Card Number: _____ Exp. Date: (month/year) ____/____

Security Code: _____ Credit Card Billing Zip Code: _____

CREDIT CARD ON FILE POLICY

All clients are required to keep a credit card on file with Wellness Counseling & Therapy Services, Inc. in order to receive services. Clients are required to pay any fees due at the time of service and are welcome to pay balances due from monthly statements in person, by mail, by phone, or by credit card on file. Your credit card will be securely stored on file to charge your card after each session for all copays, and for all non-covered service charges, co-insurances, deductibles, monthly balances, payment plan agreements, sliding scale agreements and any other accrued charges.

Signature _____ Today's Date: ____/____/____

