Electronic Payment Authorization and Policy

I, _____ , authorize Bernard J. Newton, Jr. to keep my signature on file and to charge my credit/debit/HSA/FSA card for services rendered through Newton Psychotherapy and Consulting, PLLC. I authorize Bernard J. Newton, Jr., MS, LPC, to charge my credit/debit/HSA/FSA card using internet-based transaction services and confirm that use of this service does not violate confidentiality.

Charges to this debit/credit/HSA card may include:
- Out-of-pocket expenses for each psychotherapy session
- Missed appointments (full out-of-pocket charge for the scheduled service)
- Appointments cancelled with less than 24 hours notice (full out-of-pocket charge)

If I am using a Health Savings Account (HSA) or Flexible Spending Account (FSA) payment card, I understand that even if my payment goes through and is authorized at the time that Mr. Newton charges my card, there is a possibility that the payment could later be denied. In the event of this happening, I acknowledge that I am responsible for ensuring that full payment is made by other means.

I understand that this agreement will remain valid for the duration of my treatment with Newton Psychotherapy and Consulting, PLLC. I can modify this form or revoke consent at any time through written notice to Newton Psychotherapy and Consulting, PLLC. I agree to notify Bernard J. Newton, Jr. immediately of any change in credit/debit/HSA/FSA card information.

Responsible Billing Party Name: _____
(as shown on card account)

Billing Address (as registered with card account)**:**

_____

_____

Phone Number: _____   **E-mail:** _____

For your security, Bernie will get your card information in person during your first session. If possible, please have the actual card available at that time; if not, please be sure to have access to the card's number, expiration date, and security code (on the back).

_____   _____
Client/Responsible Party Signature   **Date**