Billing address:
PO Box 2
Sharon, MA 02067

Renz Counseling

tel: 781-436-2570
fax: 781-436-5829
Billing@RenzCounseling.com

Credit/Debit Card Authorization Form

Please write clearly!

Patient name: _____

Type of card: ☐ MasterCard ☐ Visa ☐ Discover ☐ AmEx

Credit/Debit Card #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiration Date (mm/yy): ____/____ CVC Code: _____

Name as it appears on card: _____

Billing Address: _____

City, State, ZIP: _____

Cardholder's Phone #: _____

Cardholder's Email address: _____

I hereby give permission for Renz Counseling, LLC
to bill my credit/debit card, as described above,
according to the terms of the Therapist-Patient Services Agreement,
for any and all services not covered by my insurance, including:

- Co-pays / co-insurance
- Deductible
- Late cancellation fee
- Missed appointment fee
- Bank fees (e.g. returned check fees)

Signature of Cardholder: _____

Date: _____