Nicole Ashton, MA, MFT,CSAT, CCPS
Certified Sex Addiction Therapist
Certified Clinical Partner Specialist
Licensed Marriage and Family Therapist MFC # 45884
822 South Robertson Boulevard. Suite 303
Los Angeles, California 90035
Tel 310.592.8274

CREDIT CARD AUTHORIZATION

_____
(Therapy Client's Name: Please Print)

Missed Appointments
Payment for professional services is expected at the time of each session.

It is important to remember that a 24- hour notice is required to re-schedule or cancel an appointment. The full fee will be charged for sessions missed without such notification.

I,_____, am authorizing Nicole Ashton, MA.,MFT #45884 to charge the full agreed upon session fee (including a $6 per transaction service fee) to the credit card indicated below in the event that I do not attend a scheduled therapy appointment without giving a minimum of 24 hours notice.

I understand that this authorization is valid until canceled in writing. I understand that though this information is secured in my client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I understand that charges for on-going services will normally be posted to my credit card account within 24 hours of each session date and **my session fee will be charged at the start of the day on the day of my session.**

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Nicole Ashton, MA, LMFT for assistance and/or disclosure.

Initial _____

I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Nicole Ashton, MA, LMFT and those attempts have failed.

Initial _____

I agree and understand that I am individually responsible for all incurred charges even if I direct you to bill another person. If I direct charges to be billed to another person, I represent that I am authorized to give you such direction. If I have directed you to bill charges to another person who fails to make payment promptly when due, I will promptly pay on demand. If I commit to group therapy, I understand that the weekly fee for group sessions is due even if I do not attend.

Initial _____

Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by Nicole Ashton, MA, LMFT.

Initial _____

Card Type (circle one): Visa MasterCard (NOTE: I do not accept Amex)

_____ _____ _____

Card Number cvv code (3 digits on back) Expiration Date

_____

_____

Name as Printed on Card Billing Address Billing Zip Code

Relationship to client:_____

I have read the above Fee Agreement document carefully, and I understand it and agree to comply with all its terms and conditions:

_____

Name of Client Signature Date