



Samaritan Health & Living Center
311 W. High St.
Elkhart, Indiana 46516
574-262-3597 ♦ 574-262-3599 fax
www.ElkhartSamaritan.org

CREDIT CARD RECURRING PAYMENT AUTHORIZATION FORM

If you choose to use a debit or credit card to pay for sessions, please complete and sign this form to authorize the Samaritan Health & Living Center, dba the Samaritan Center, to use the debit/credit card information on file as payment for your counseling sessions.

How Recurring Payments work:

You authorize the Samaritan Center to charge your **Visa or MasterCard** for the payment amount due for each session. These payments reflect the agreed upon co-pay/co-insurance/adjusted fee per session. As such, the actual amount charged may change per session depending on matters such as (but not limited to): 1) a change in your fee assistance price, 2) having met a deductible for your insurance company 3) your need for a therapist to charge you for more than one session at one time. In total, the Samaritan Center will not charge your card more than what is outlined on the Statement of Agreement form (part of your intake packet).**

You also authorize the Samaritan Center to automatically charge your card for any Late Cancellation or No Show appointments based on the guidelines established in the Statement of Agreement and discussed between yourself and your therapist. **Client's Initials** _____

PLEASE COMPLETE THE INFORMATION BELOW:

I, (full name) _____, authorize The Samaritan Center to charge my debit/credit card on file as those charges line up with the above guidelines and those of the Statement of Agreement form.

Billing Address: _____ City, State, Zip: _____

Cardholder Name: _____
Account Number: _____
Expiration Date: _____
CVV (3 digit number on the back of Visa/MasterCard): _____

I authorize the above named business to charge the debit/credit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the organization in writing of any changes in my account information. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the authorized payments with my card company provided the transactions correspond to the terms indicated in this authorization form.

Signature: _____

Date: _____