Institute for Couple and Family Enhancement
PRE-AUTHORIZED BILLING AGREEMENT

I authorize my therapist named below to keep my credit card information and signature on file. Charges will only be made to my card for the following reasons:

- **Appointments attended**- I may request for my card to be charged after each appointment to save time at the end of each session.
- **Returned checks**- I understand that my card will be charged for any outstanding balance on my account plus a $30 administrative fee for returned checks.
- **Charges for missed appointments**- I understand that my therapist has a 24-hour cancellation policy and my card will be billed for the full amount of any session if I do not attend a schedule session that is not cancelled or rescheduled at least 24 hours prior to the scheduled time and day.

I understand that my credit card information will be destroyed 60 days after the last session that I attend with my therapist, in compliance with Texas law. I may revoke this agreement at any time by providing a request in writing.

ICFE Therapist _____

Client Name _____

Card holder's Name _____

Card holder's Address _____

City _____ State _____ Zip _____

- ❑ Visa Security code (3 digits on back) _____
- ❑ Discover Security code (3 digits on back) _____
- ❑ Mastercard Security code (3 digits on back) _____

Account Number _____

Expiration Date _____

Signature below acknowledges client agreement with terms above, and agreement to pay total balance according to the card issuer agreement.

Signature _____