



Payment Authorization Responsible Party for Billing

Lisa Sciarani / Your Path Forward Counseling, LLC (the “Therapist”) may utilize my payment method(s) on file for any balances, including co-pays, late cancellation fees, and no-show fees, without additional authorization for _____ (the “Client”).

By signing, I understand and agree with the following terms and conditions:

- My card will be used as the default payment method for ongoing services unless other arrangements have been made, as described below.
- My card information will be stored in the client's file and is protected by encryption software.
- The Therapist is permitted to charge my card without me or the aforementioned client being physically present. I understand that my card may be charged as soon as at the beginning of a scheduled session, even if the appointment is missed or late canceled. Due to HIPAA restrictions around client confidentiality, the therapist may not inform me when or why the card is being charged.
- I will inform both the Therapist and the aforementioned client immediately if circumstances arise where my card on file should not be charged.
- I have the right to withdraw this consent at any time. I understand that consent cannot be withdrawn retroactively.
- My card(s) will remain in client's file and may be used as a back-up payment method whenever necessary to pay for services and fees, unless I withdraw this consent.
- I understand that no refunds will be issued under any circumstances for services rendered or assessed fees. This is true regardless of client's ongoing engagement in services, satisfaction with services, or my relationship status with the client.

Billing Responsible Party/Cardholder Signature

Date