8280 College Parkway, Suite 103
Fort Myers, FL 33919

Third-Party Payment Authorization

At SWFL Counseling, LLC, payment is expected at the time of service. At times, someone other than the person seeking counseling will be providing payment for the session. Please complete and return this form to designate a third-party to provide payment for your counseling services.

Cardholder Name: _____

Billing Address: _____

_____

Phone Number: _____ Send receipt via text message ☐

Email: _____ Send receipt via email ☐

Card Number: _____

Expiration Date: _____ CVV: _____ Billing Zip Code: _____

Amount to Charge: _____

I authorize the counselor to charge the amount listed above to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder's Signature: _____

Printed Name: _____

Date: _____

Client Signature: _____

Printed Name: _____

Date: _____

Counselor Signature: _____

Printed Name: _____

Date: _____

A copy of this form will be filed in the client's medical record and utilized for the **duration of treatment**. If this arrangement changes for any reason, it is the **client's responsibility** to notify the counselor and provide alternate payment arrangements.