THE GOLD STANDARD
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AUTHORIZATION FOR CREDIT CARD BILLING

This form is for your convenience to take care of any balances. Your card will be processed at the conclusion of any appointments or unapproved missed appointments per the Appointment Cancellation Policy.

Receipt Choice: ☐ Emailed _____ ☐ No Receipt

Client Name: _____

Cardholder Name:	
Card Number:	
Expiration:	CVC:

Appointment Cancellation Policy: I understand that if I must cancel or change a scheduled appointment that I must do so 24-hours in advance. Appointments cancelled or changed less than 24-hours in advance will be charged at the full fee.

Fees/Collections: I understand that a fee arrangement will be made with me at the commencement of treatment and that payment is due prior to or at the time of each session. I also understand that checks returned for nonpayment will result in an additional $25 charge for administration costs. Any changes in the fee arrangement must be made directly with either Dr. Casey Cooper. I also understand that if I fail to pay for services promptly collection action may be taken. I will be responsible for any attorney fees and other collection costs.

Please be advised that the Card Holder Signature Authorizes The Gold Standard to charge the Card Holder's credit card account. Should your card not process successfully, it is the Card Holder's responsibility to make prompt payments towards any outstanding balances prior to the next appointment.

_____ _____

Card Holder's Signature Date