SHERMAN COUNSELING
Improving Quality of Life

W6144 AEROTECH DR. APPLETON, WI 54914 | PHONE: 920.733.2065 | FAX : 920.733.6565

Credit Card Authorization

Sherman Counseling encourages keeping your credit or debit card on file as a convenient method of payment for the portion of services that you are liable. This includes copays, co-insurance, deductible, No Show/Late cancel fee, etc.

Your financial information is kept confidential and secure. Clients utilizing their insurance benefits, payments are processed only after the claim has been filed and processed by your insurer indicating your responsibility. Copays and Selfpay fees will be processed the next business day after the date of service.

Credit card information		
❑ Amex ❑ Visa ❑ Mastercard ❑ Discover	Credit Card #	
	Expiration: _____/_____	CCV:
	Cardholder's Name:	

Cardholder Signature: _____ Date: ____/____/_____

I understand that this authorization will remain in effect until I cancel it in writting and I agree to notify Sherman Counseling in writing of any changes in my account information or termination of this authorization by the 1st of the next billing month. I certify that I am an authorized user of this credit card/ bank account and will not dispute these scheduled transactions with my bank or credit card company so long as the transactions indicated in this authorization form.

Client's Name: _____ DOB: ____/____/_____

Billing Address: _____ City_____ Zip_____

Phone Number: (____) _____ - _____

*******Charges for the ENTIRE patient balance will be processed the first week of each month unless noted otherwise in the highlighted portion below*******

Exception – Day of each month to be billed: _____ (Example: 15th of each month)

*****If payment exceeds $_____, please call for approval*****