Breath of Life Counseling Services
107 Cedar Grove Lane, Suite 103E
Somerset, NJ 08873
732-289-6008

By signing this agreement, I am authorizing Breath of Life counseling Services to charge my credit card for all professional services rendered to the "client" that are not paid at the time of service, or for situations which fall under the late cancelation policy listed below. I agree that I will not dispute those charges (charge back) which may include, but are not limited to:

- A missed session that has not been cancelled with 24 hour's notice will charged the full session fee which cannot be billed to insurance, as outlined in the Cancellation Policy.
- Telephone sessions in prorated increments of 15 minutes.
- Deductibles, Co-pays, Session Fees not paid by client's insurance.

This form will be stored securely in the client's clinical file and updated upon request at any time.

Card Number: _____

Security Code: _____ Expiration Date: _____

Name as Printed on Card: _____

Card Type: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Signature: _____