

Reflective Counseling Services

Helping you achieve your mental and emotional wellness goals

Client's Name: _____

Credit Card Holder's Name (as it appears on the card): _____

Phone # of Card Holder: _____

Email of Card Holder: _____

Type of Card: Debit Credit HSA/FSA

Card Number _____ - _____ - _____ - _____

Expiration Date _____ 3-digit Security Code _____

Billing Address _____

I authorize Reflective Counseling Services to charge the credit, debit or HSA card provided for copays each visit and any additional charges I occur for behavioral health care services.

I understand that I may cancel this authorization upon written notice to Reflective Counseling Services.

Card Holder Signature _____

* RCS will keep all card and personal information secure.