Payment Authorization Form

SECTION 1 - Merchant Information

Merchant name: Family Houston
Merchant address: P.O. Box 70068, Houston, TX 77270
Merchant phone number: (713) 861-4849
Email address: clientinvoices@familyhouston.org

SECTION 2 - Authorization Agreement

I,_____, authorize *Family Houston* to charge my debit/credit card at the time of my session.

I understand that:

- I will be responsible for a payment of $25.00 for appointments cancelled with less than 24 hours' notice, except in the case of emergencies.
- Cancellation fees apply to all clients except for Medicaid clients.
- After three failed payments, service will be suspended until the balance is paid in part or in full.
- My information will be saved for future transactions on my account and the authorization will remain in effect until I formally request cancellation.
- I am responsible for keeping my card information accurate and up to date.
- All fees related to copay, coinsurance, deductible, and no show will be drafted from my card within 3 business days from the date of service.
- If I am unable to make payments, I can contact billing at 713-861-4849 or clientinvoices@familyhouston.org for an account review.
- I have the option to request payment plan information.

☐ By checking this box, I am allowing Family Houston to email me the invoices for services provided.

Signature:_____**Date**: _____