

**Compass Counseling Wausau, LLC
Payment authorization form**

Please complete all fields.

Credit Card Information: PLEASE CIRCLE

Visa Mastercard Discover Amex Other: _____

Card Holder Name: _____

Card Number: _____

Expiration Date: _____

Security Code: _____

Card Holder Zip: _____

ACH Debits/Bank account information: PLEASE CIRCLE

Checking Savings

Bank Name: _____ Branch: _____

City: _____ State: _____ Zip: _____

Routing Number: _____

Account Number: _____

I, _____ authorize Compass Counseling Wausau, LLC to charge my credit card above for agreed upon services. I understand that my information will be stored for future transactions on my account. I understand that this card/bank account will be charged my patient responsibility as indicated on each EOB from my insurance company and also in accordance with the late cancellation/no show policy. **This authorization will remain in full force and effect until Compass Counseling has received written notification from me of its termination in such time and in such manner as to afford Compass Counseling a reasonable opportunity to act on it.** I acknowledge that the origination of ACH transactions to my account must comply with the provisions of US law.

Customer Signature

Date

For office use only:

Date terminated: