COBYS Family Services
1417 Oregon Road, Leola, PA 17540
Phone: 717-661-3548 · Fax: 717-656-3056
www.cobys.org

Authorization Agreement for Credit Card Payment for Counseling Services

For payment to COBYS Family Services via your credit card account, simply complete and sign the form below. Your payment will appear on your statement.

Name Printed on Credit Card ____

Card Account Mailing Address ____

City ____ **State** _______ **Zip Code** _____________

E-mail Address ____ **Telephone** _________________________

USE FOR RECURRING CHARGES ONLY

I understand that my credit card account will be charged in the amount of $__________ immediately after each session.

I also understand that my credit card account will be automatically charged for any unpaid balances, including session fees, co-payments, deductibles, coinsurance, and failed appointment and late cancellation charges.

Please tell us how long you want us to automatically bill your credit card:

____ This authorization is valid until I provide you with written cancellation.
____ This authorization is valid until _______________________________

USE FOR ONE TIME CHARGES

____I understand that my credit card account will be charged in the amount of $_____________ for a one time only charge.

____ Visa ____ MasterCard ____ Discover ____ American Express

Account number: ________________________________ **CVV Number:** _______ **Expiration Date:** ___________

I hereby authorize COBYS Family Services to charge my credit card as designated above.

Signature ____ **Date** ________________________

You may cancel this automatic billing authorization at any time by contacting us in writing at COBYS Family Services, 1417 Oregon Road, Leola, PA 17540. For questions, contact Counseling Administrative Assistant Sheila Thum at 717-661-3548 or sthum@cobys.org