CARD AUTHORIZATION

I, _____, the responsible party for

□ Myself □ _____

hereby authorize Groff & Associates, LLC to charge payments to the following credit/debit card for physical and/or emotional health care at Groff & Associates, 7425 East 86th Street, Indianapolis, IN 46256 (Physical Address) or P.O. Box 502246, Indianapolis, IN 46250-7246 (Mailing Address).

I understand any debit card that returns for non-sufficient funds (NSF) will result in a $30.00 NSF fee in addition to the clinical fee for services rendered. I understand I may choose any other qualified payment option (i.e. cash, check, or HSA flexible spending**) at the time of service. I also can revoke this credit card authorization at any time. ****Please Note: Not all Health Flex Cards can be utilized at Groff & Associates based on your health insurance policy.**

Credit Card Information: _____ VISA _____ MASTERCARD _____ DISCOVER

Cardholder Name (as written on card): _____

Billing Address: _____

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____ (mm/yyyy)

CCV Number (three digit number located on back of card): _____

Please choose one of the following payment options:

□ $_____ payable at end of session on _____.

□ $_____ payable at end of each health care session at Groff & Associates.

_____ _____

Signature of Client/Responsible Person **Date**