Institute for Couple and Family Enhancement
PRE-AUTHORIZED BILLING AGREEMENT

I authorize Nicholas Wilkens, Ph.D, on behalf of the ICFE, to keep my credit card information and signature on file. Charges will only be made to my card for the following reasons:

- **Appointments attended**- I may request for my card to be charged after each appointment to save time at the end of each session.
- **Returned checks**- I understand that my card will be charged for any outstanding balance on my account plus a $25 administrative fee for returned checks.
- **Charges for missed appointments**- I understand that the ICFE has a 24-hour cancellation policy and my card will be billed for the full amount of any session if I do not attend a schedule session that is not cancelled or rescheduled at least 24 hours prior to the scheduled time and day.

I understand that my credit card information will be destroyed 120 days after the last session that I attend with my therapist. I may revoke this agreement at any time by providing a request in writing.

ICFE Therapist _____

Client Name _____

Card holder's Name _____

Card holder's Address _____

City _____ State _____ Zip _____

- ❑ Visa Security code (3 digits on back) _____
- ❑ Discover Security code (3 digits on back) _____
- ❑ Mastercard Security code (3 digits on back) _____

Account Number _____

Expiration Date _____

Signature below acknowledges client agreement with terms above, and agreement to pay total balance according to the card issuer agreement.

Signature _____