



HEATHER WILLIAMS, MFT

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CREDIT CARD AUTHORIZATION FORM

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request.

I _____, am authorizing Heather Williams, MFT to use my credit card information to charge my credit card in the event that:

___ I do not cancel my appointment at least 24 hours in advance (**\$75.00 cancellation fee will apply**)

___ A check is returned for any reason (additional \$35 fee for returned checks)

___ There is an outstanding balance including denial of insurance benefits/claims, deductibles not met or inaccurate co-pay amounts.

___ I am electing to use this card for co-pay fees

Type of Card: VISA MasterCard American Express Discover

Card Number: _____

Verification/ Security Code: _____ Exp. Date: _____/_____/_____

Address of Cardholder (if different than client) _____

Cardholder Date of Birth

Client Signature

Date