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, LMFT 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 **($100.00 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 _____