DEBBIE GROSS, LCSW, Ltd.
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CREDIT CARD AUTHORIZATION FORM

Date: _____

Name of the cardholder as it appears on the card: _____

Credit card type: (Circle one) Mastercard Visa Discover Amer Exp

Credit card number: Exp date: 3 digit security code

_____-_____-_____-_____ _____ _____

Email address for receipts and billing: _____

Mailing address that the credit card is billed to: _____

_____

The following people are included in any billing related to the above charge card:

_____

I agree to pay the charges added to my credit card account for charges in the following situation(s), including stated service charges (check all that apply)

_____ I understand the following service charges will apply: 3% if card is swiped, 4% if entered manually

_____ My therapist is not on my insurance plan: if I do not pay at the time of service or do not provide 24-hour notice to cancel an appointment, I authorize her to charge the office visit fees to my credit card within 24 hours of the scheduled appointment

_____ My therapist is on my insurance plan: I am responsible for all deductibles, copays and other charges. Please charge my credit card for any charges I leave unpaid or delinquent, if I fail to give 24-hours notice to cancel an appointment, or if I request to pay my fees with my credit card.

This information will be kept in a locked, secured location and destroyed upon the completion of services and full payment of your bill.

Cardholder signature: _____ Date: _____