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 at any time.

I, ____, authorize Megan Taylor, LMHCA, to charge my credit card for professional services as follows:

Please Initial:

________ Recurring charges for services in the amount of $___________ per visit.

________ I understand and agree that my card will be charged a fee of $100.00 for cancellations with less than 24 hours notice and for appointments I miss without notice as agreed to in the Client Consent and Disclosure Form I signed.

________ I understand and agree that my card will be charged for balances of charges not paid by me or my insurance (such as deductibles and copays).

________ I understand this form is valid for one year unless I cancel the authorization in writing. I will not dispute charges ("charge back") for sessions I have received or appointments I missed according to the above policy.

Charges will appear on your credit card statement as "Megan Taylor**"**

☐ Visa ☐ MasterCard ☐ Debit Card

Card #: ____

Expiration Date: ____

Name as Printed on Card: ____________________________________

Verification/Security Code (the 3---digit code on back of card by signature line): _____________

Billing Address (Street, City, State & Zip): ____________________________________

____

Email Address:

Signature		Printed Name		Date	