Lacamas Counseling
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LACAMAS COUNSELING & PSYCHIATRY

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 Lacamas Counseling to charge my credit card for professional services as follows:

Please Initial:
_____ I agree to pay for sessions provided for _____ (client name)
_____ I understand and agree that my card will be charged $100.00 for missed appointments or appointments canceled with less than 24 hours notice
_____ I understand and agree that my card will be charged for outstanding balances

Cardholder Name: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number (last 3 digits located on the back of the credit card): _____

Print Name, Sign and Date Below:

Signed: _____

Name: _____

Date: _____