lift

long island family therapy

Credit Card Authorization Form

THIS INFORMATION IS PRIVATE AND CONFIDENTIAL
AND WILL BE KEPT ON FILE ONLY BY
_____

Name as it appears on credit card:_____
(name must be that of cardholder)

Phone number of card holder:_____

Billing address of credit card including name of cardholder and address with zip code:
_____

Email address of cardholder: _____

Card (Choose One) ___Visa ___Master Card ___Discover ___American Express

Credit Card Number:_____

Expiration Date: Month/Year _____CCV OR CID Code: _____

All patients are required to have an active credit card on file. Payment is due at the time of service, or at the session following a "no show" defined as a cancellation with less than ___ hours notice. If you prefer to pay by cash or check, please do so at the time of service, or at the session following a "no show." If payment is not received at the time of service or at the next session following a "no show," (*your credit card will be charged for the balance due*.) *or* (*we will wait ten (10) days for a check to be received by mail. After 10 days your credit card will be charged for any balance due*.)

An additional charge of ____% is imposed for payments made by credit card. The additional charge will be itemized on your statement.

I/we hereby authorize the above credit card to be used for payments for services rendered by_____ to (patient) _____. This authorization will remain in effect until the expiration date of the card or a written request to revoke the authorization is sent to us at (address):_____

_____.

Please advise us immediately if your card is lost and/or stolen.

Card Holder Signature: _____ Date:_____

Patient Signature (if not cardholder):_____ Date:_____