Authorization to Charge Credit Card for Services

Client's Name: _____

Telephone Number: _____

Name on Credit Card: _____

Client's Mailing Address on credit card (including zip code):

_____ (zip) _____(_____)

Credit Card Number: _____(CVC)_____

Expiration Date: _____

In the event that the client's insurance fails to pay Lynda Keen, LPC, for a scheduled counseling session, the client agrees to allow the counselor to charge the session fee to the credit card number provided above. You will receive notification by mail. If you prefer not to use your credit card, our office will take a cash or check deposit on account for one session fee which will be refunded when notice is given of intent to terminate services. In addition, the client agrees to allow this card to be charged for full session fee for any counseling session that has not been cancelled 24 hours prior to the session time. Insurance will not pay for missed sessions. Every effort will be made to reschedule your appointment the same week if you must cancel without 24 hours notice. If this is not possible, or you miss an appointment without calling to cancel or reschedule, your credit card will be charged at the full session fee with notification by mail.

Signature: _____Date: _____