De Santo Counseling
Sue De Santo, LCSW

CREDIT CARD AUTHORIZATION

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 Sue De Santo, LCSW to charge my credit/debit 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 the full fee of should any of the following situations arise:

  _____ Cancellations with less than 24 hours notice for daytime appointments.

  _____ Cancellations with less than 48 hours notice for evening and weekends.

  _____ Appointments I miss without notice (no-shows).

  _____ Insurance refusal to pay for services.

- _____ I will not dispute charges ("charge back") for sessions I have received, non-payment by insurance company, or appointments I missed according to the above policy.
- _____ I understand this form is valid for one year unless I cancel the authorization in writing.

Charges will appear on your credit card statement as sue@desantocounseling.com
Card Type (circle one): Visa MasterCard Discover

Card #: _____

Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code: _____
(**MC/Visa/Discover**: the 3-digit code on back by signature line).

Email Address: _____

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

_____

_____

Signature: _____

Date: _____