ELECTRONIC PAYMENT AUTHORIZATION

Name_____Date of Birth_____

Address_____City_____Zip_____

Home Phone_____Cell Phone_____SSN_____

Email_____

Billing Information associated with the credit or debit card you wish to use:

Name on card *(if different)*_____

Address *(if different)*_____City_____Zip_____

I authorize all service fees to be deducted from the card ending in _____ (last 4 digits)
I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

Full Name of Patient_____

I understand that this form authorizes LeAnne Pleasant, LCSW to charge this card for varying session types, across multiple dates of service including charges for Late Cancellation or No Show appointments. By authorizing use of this card, and signing this Electronic Payment Authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

_____ _____

Cardholder Signature **Date**

Please provide the card information below. <u>This information will be destroyed once your information has been securely encrypted and stored.</u>

The card type is (circle one) VISA MASTERCARD DISCOVER

Card Number_____

Expiration Date_____ CVV_____(from back of card)