

ELIZABETH A. SMITH LCSW, ACSW Authorization to charge client credit card

ELIZABETH SMITH M.A. LCSW, ACSW

CLIENT INFORMED CONSENT REGARDING CREDIT CARD

SIGNED CONSENT TO GIVE PERMISSION FOR PROVIDER ELIZABETH A. SMITH LCSW TO CHARGE MY CREDIT CARD FOR COPAYS, MISSED SESSIONS W/OUT 24 HOUR CANCELLATION NOTICE

The client signature below and credit card information and date gives client consent about the office policy to client credit card when indicated for copays due ( at beginning of the session and coinsurances as determined by their insurance policy as stated on the EOB's / insurance card.

Please provide credit card information below so it can be used for the above purpose only for a period of three months. This can be stopped at any time with your permission. Provider agrees to keep it in a locked file cabinet in your file according to HIPAA regulations.

Your signature below will give your permission and informed consent to the provider Elizabeth A. Smith LCSW to charge your credit card. If you have any questions please ask the provider before signing.

Thank you.

Elizabeth A. Smith LCSW

Signature of client ----- date-----

Type of credit card-----

Credit card # -----

Name as it appears on credit card-----

Expiration date-----

Three digit number on back of card for security -----