Sue M. Bushrow LMFT
Licensed Marriage & Family Therapist

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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. All clients are required to have a valid credit card authorization on file

I, _____, authorized ***Sue Bushrow, LMFT*** to charge my credit/debit card for professional services as follows:

CANCELLATIONS, NO-SHOWS, AND NON-INSURANCE PAYMENTS ARE BILLED AT THE FULL RATE OF $85 PER SESSION.

I understand and agree that my card will be charged the amount stated above should any of the following situations arise (please initial each item below):

_____Cancellations with less than 24 hours notice

_____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 miss according to the missed or cancelled appointment policy.

CARD TYPE_____ VISA_____MASTERCARD_____ AMERICAN EXPRESS_____

CARD #_____EXP DATE_____SECURITY CODE_____

NAME ON CARD_____

EMAIL ADDRESS_____

BILLING ADDRESS (Street, City, St. & Zip)_____

_____

CLIENT'S NAME (PRINTED)_____

_____

PARENT/GUARDIAN'S NAME AND RELATIONSHIP TO MINOR CLINET (PRINTED)

_____

CLIENT SIGNITURE_____DATE_____