

Julie Cavese, MA, LPC
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Credit Card Authorization Form

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 Julie Cavese, LPC to charge my credit card for professional services as follows:

Please Initial:

_____ I understand and agree that my card will be charged a fee of \$100.00 for cancellations with less than 24 hours notice and for appointments I miss without notice as agreed to in the Client Informed Consent and Disclosure Form I signed.

_____ I understand and agree that my card will be charged for balances of charges not paid by me or my insurance (such as deductibles and copays).

_____ 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 "Julie Cavese, MA, LPC"

____ Visa ____ MasterCard ____ American Express ____ Other

Card #: _____ Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code: _____ Billing Zip: _____

Signature _____ Date _____