Julie Cavese, PsyD, LPC
1020 SW Taylor St. Suite 448
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503-512-9198

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 $75.00 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, LPC”

_____Visa _____MasterCard _____American Express _____Other

Card #: _____________________________________ Expiration Date: ___________

Name as Printed on Card: ____

Verification/Security Code:__________ Billing Zip:______________

Signature ______________________________________ Date________________