A. Rachel Weiss, MSW, LCSW

INDIVIDUAL | COUPLE | EMDR THERAPY

Credit Card on File Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting me. Please note that I do not take patients on, or agree to continue therapy with existing patients, without having a card on file, unless you are paying up front monthly for your sessions. This authorization will remain in effect until cancelled, and/ or until you terminate treatment and have paid any money owed. This form will be securely stored in your clinical file and may be updated upon request at any time.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____ Is this an HSA Card? Y N
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CVV (security code): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize A. Rachel Weiss, MSW, LCSW to charge my credit/debit card above for the agreed upon Late Cancellation and Missed Appointment fees outlined in the Payment Policy Document. I will be responsible for any check that is returned unpaid, I will not dispute charges ("charge back") for sessions I have received, or appointments I have missed, according to the signed, agreed on, policy. I understand that if my card cannot be processed, I will owe an additional $30.00 late payment fee if not corrected *before* 9pm on the day the payment is due. I understand that it is my responsibility to ensure that information is updated when anything changes with my credit card (i.e. new zip code, expired card, new card, etc.).

_____ _____

Cardholder's Signature Date

_____

PRINT PATIENT'S NAME (if *not* the cardholder)