Credit Card Authorization

You are responsible for paying your full fee for services at the time the services are rendered. We ask each patient to keep a current form of payment in their file. In the event a patient misses an appointment or fails to cancel the appointment 24 hours in advance, he or she will be required to pay in full for the session.

All merchant (credit card) processing is done through a secure app at the end of each business day. By signing this form, I authorize the office of Rose J Testa LCSW, LLC to charge all the applicable fees for services. This includes late, failed, and canceled or “no show” fees per the signed client agreement. 24 hours’ notice is required to cancel individual, family, play and group therapy. A credit card number is required to book initial appointment and the cancellation policy also applies.

Circle One:VISA MASTERCARD AMEX HSA CARD

Name as Written on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code: \_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_

Billing Address 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Associated with Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am in agreement with Rose J. Testa, LCSW, LLC, and I understand it is my responsibility to pay for treatment at the time services are rendered. I give permission to Rose J. Testa, LCSW, LLC, in the event that I fail a scheduled appointment, or fail to cancel 24 hours prior to the appointment, to charge my credit card on file for full session fee.

Signature / Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_