

**Carrie Greiner, LCSW  
1805 N. Mill St. Ste. B  
Naperville, IL 60563**

**Authorization to Secure Payment**

I, \_\_\_\_\_ authorize Carrie Greiner, LCSW, Dr. Kimberly A. Lemke, P.C, and SR and R Counseling Inc., and those working on the practice's behalf, to process payment on my Visa, MasterCard, or Discover Card for any balance due that has not been paid **30 days after it has accrued.**

I understand if the appointment is missed and I do not follow the cancellation policy as specified, Carrie Greiner, LCSW, Dr. Kimberly A. Lemke, P.C, and SR and R Counseling Inc. and those working on the practice's behalf, are authorized to charge my credit card the same day as the missed appointment.

I understand that if my card is declined, Carrie Greiner, LCSW, Dr. Kimberly A. Lemke, P.C, and SR and R Counseling Inc. and those working on the practice's behalf, may put my credit card payment through on another day when funds become available.

I understand that I have given Carrie Greiner, LCSW, Dr. Kimberly A. Lemke, P.C, and SR and R Counseling Inc. and those working on the practice's behalf, my credit card information to keep on file. I further understand that if I miss a scheduled appointment or fail to provide 24 hours notice, my credit card will be charged the full amount of the session.

I have read and understand this form. I attest that the information below is true and accurate.

\_\_\_\_\_

**Signature of Cardholder**

**My credit card information is as follows:**

\_\_\_\_\_

Cardholder's Name

\_\_\_\_\_

Client's Name

\_\_\_\_\_

Credit Card Account Number

\_\_\_\_\_

Expiration Date

\_\_\_\_\_

CVV

\_\_\_\_\_

Address

\_\_\_\_\_

Zip Code

Is this a debit card? ☐ Yes ☐ No

Is this an HSA card? ☐ Yes ☐ No

\_\_\_\_\_  
Today's Date

Please indicate if you would like your session Co-pay automatically charged to your Credit card.

☐ Yes ☐ No Amount of Co-Pay \_\_\_\_\_

**By providing the following e-mail address, I give Carrie Greiner, LCSW, Dr. Kimberly A. Lemke, P.C, and SR and R Counseling Inc. and those working on the practice's behalf, the authorization to communicate with me/ and or submit a bill to**

**the e-mail address listed below. I also understand that by providing the following e-mail address, I accept the HIPAA risks associated with electronic submission of data.**

**E-mail Address:** \_\_\_\_\_