Maria Gianunzio, Ph.D.
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Authorization to Secure Payment

I, _____ authorize Dr. Kimberly A. Lemke, P.C., Mary Englund PsyD, LLC and Maria Gianunzio, PhD., 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, Dr. Kimberly A.Lemke, P.C., Mary Englund, PsyD, LLC and Maria Gianunzio, PhD., is authorized to charge my credit card the same day as the missed appointment.

I understand that if my card is declined Dr. Kimberly A. Lemke, P.C., Mary Englund, PsyD, LLC and Maria Gianunzio, PhD., may put my credit card payment through on another day when funds become available.

I understand that I have given Dr. Kimberly A. Lemke, P.C., Mary Englund, PsyD, LLC and Maria Gianunzio, PhD., 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.

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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 Dr. Kimberly A. Lemke, P.C., Mary Englund, PsyD, LLC and Maria Gianunzio, PhD., **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.**

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