Dr. Kimberly A. Lemke, P.C.
1805 N. Mill St. Ste. B
Naperville, IL 60563

Authorization to Secure Payment

I, ____ authorize Dr. Kimberly A. Lemke, P.C., 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., 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., 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., 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 Card Holder

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

____
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 Dr. Kimberly A. Lemke, P.C., **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: ____