Samantha McGann, LSCW
1805 N. Mill St. Ste. B
Naperville, IL 60563

Authorization to Secure Payment

I, ____authorize Samantha McGann, LSCW, Dr. Kimberly A. Lemke, P.C.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, Samantha McGann, LSCW, Dr. Kimberly A. Lemke, P.C.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, Samantha McGann, LSCW, Dr. Kimberly A. Lemke, P.C.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 Samantha McGann, LSCW, Dr. Kimberly A. Lemke, P.C.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? Is this an HSA card?
☐ Yes ☐ No ☐ 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 Samantha McGann, LSCW, Dr. Kimberly A. Lemke, P.C.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: ____