

**Kara Morgan, LCSW  
1805 N. Mill St. Ste. B  
Naperville, IL 60563**

**Authorization to Secure Payment**

I, \_\_\_\_\_ authorize Kara Morgan, LCSW, 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, Kara Morgan, LCSW, 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, Kara Morgan, LCSW, 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 Kara Morgan, LCSW, 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?		
<input type="checkbox"/> Yes <input type="checkbox"/> 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 Kara Morgan, LCSW, 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:** \_\_\_\_\_