

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

**Authorization to Secure Payment**

I, \_\_\_\_\_ authorize Kara Morgan, LCSW and 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, Kara Morgan LCSW and 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 Kara Morgan LCSW and 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 Kara Morgan LCSW and 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

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 Kara Morgan LCSW and 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:** \_\_\_\_\_