Samantha McGann, LCSW
1805 North Mill Street, Suite B
Naperville, IL 60563

Authorization to Secure Payment

I, _____authorize Dr. Kimberly A. Lemke, PC, Mary Englund PsyD, LLC and Samantha McGann, LSCW. to process payment on my Visa, MasterCard, or Discover Card for any balance due that has not been paid **30 days after the balance is accrued.**

I understand that if the appointment is missed and I do not follow the cancellation policy as specified Dr. Kimberly A. Lemke, PC, Mary Englund PsyD, LLC and Samantha McGann, LCSW is authorized to charge my credit card the same as the missed appointment.

I understand that if my card is declined, Dr. Kimberly A. Lemke, PC, Mary Englund PsyD, LLC and Samantha McGann, LCSW may put my credit card payment through on another day when funds become available.

I understand that I have given Dr. Kimberly A. Lemke, PC, Mary Englund PsyD, LLC and Samantha McGann, LCSW my credit card information. 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 CVV

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, Psy.D., LLC and Samantha McGann, LCSW 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: _____