

**Samantha Zurek, MA, NCC, LCPC
1805 N. Mill St. Ste. B
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Authorization to Secure Payment

I, _____ authorize Dr. Kimberly A. Lemke, P.C., Mary Englund PsyD, LLC and Samantha Zurek, MA, NCC, LCPC 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., Mary Englund, PsyD, LLC and Samantha Zurek, MA, NCC, LCPC 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., Mary Englund, PsyD, LLC and Samantha Zurek, MA, NCC, LCPC 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., Mary Englund, PsyD, LLC and Samantha Zurek, MA, NCC, LCPC 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., Mary Englund, PsyD, LLC and Samantha Zurek, MA, NCC, LCPC 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: _____