Ashley Smith, LCSW
1805 N. Mill St. Ste. B
Naperville, IL 60563

Authorization to Secure Payment

I, _____authorize Ashley Smith, LCSW, Dr. Kimberly A. Lemke, P.C, and SR and R Counseling Inc., 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, Ashley Smith, LCSW, Dr. Kimberly A. Lemke, P.C, and SR and R Counseling Inc. 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, Ashley Smith, LCSW, Dr. Kimberly A. Lemke, P.C, and SR and R Counseling Inc. 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 Ashley Smith, LCSW, Dr. Kimberly A. Lemke, P.C, and SR and R Counseling Inc. 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? □ Yes □ No Is this an HSA 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 Ashley Smith, LCSW, Dr. Kimberly A. Lemke, P.C, and SR and R Counseling Inc. 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: _____