Credit Card Authorization Form

To cover expenses for copayments or fees for cancelled sessions, I ask you to give me a credit card number to keep on file.

I, ____________________________________, hereby Nicola Simmersbach PsyD LMFT to bill my credit card as listed below for professional fees for missed sessions not cancelled 24 hours prior to scheduled start time..

I agree not to submit chargebacks through my credit card provider and will contact Nicola Simmersbach, PsyD LMFT, directly in the event that I feel my card was charged in error. Credit card payments that are disputed though the credit card company and found to be valid are subject to a $75.00 fee per chargeback.

I agree that Nicola Simmersbach PsyD LMFT may bill my credit card the full fee for professional services including the following:

Please initial:

_____ Appointments that I elect to pay by credit card. (Please bring in card to run through terminal)

_____ Missed appointments. (Full fee)

_____ Appointments that I have canceled with less than 24 hours' notice. (Full fee)

_____ Balances of charges not paid by me or my insurance.

_____ Insufficient funds/returned checks and bank charges for those.

Charges will appear on your credit card statement as Nicola Simmersbach or some variation of it.

Type of Card: (check one):[] Visa [] MasterCard [] Discover [] American Express

Name as it appears on card: __________________________________

Card Number: _____________________Expiration Date: ___________

CVV2/CID Security Code: ______________

Zip code of billing address: _______________

Signature: __________________________________Date: _______________