# Dr. Ruthie Norman LICSW LLC

Trauma Treatment & Recovery Psychological Services

## DEBIT OR CREDIT CARD AUTHORIZATION FORM

| Card Information |
| --- |

Card Type: ☐ Discover ☐ Visa ☐ Mastercard ☐ Other

Cardholder Name: (as shown on card)_____

Card Number: _____

Card Verification Value: (3 digit on back of card) _____/_____/_____

Card Expiration Date: (mm/yy)_____/_____

Cardholder Zip Code: (from card billing address) _____

I authorize Dr. Ruthie Norman, LICSW, LLC to charge my debit or credit card above for any balance incurred on my account, including missed appointment fees, copayments, co-insurance or any amount determined by my insurance company or to be my responsibility. These amounts will be charged to my debit or credit card as the expenses are incurred. I understand that my information will be saved to file for future transactions on my account. I understand that if my card is declined I may be charged a late fee each month from that day forward until my account is paid in full. I will provide updated card information if changes should occur.

My signature below confirms that this document has been explained in a manner that is clear to me and that all questions I had regarding this document, were answered to my satisfaction.

_____ _____

NAME DATE

_____

SIGNATURE