EMILY MARKOWITZ, LMSW LCSW

Psychotherapy

CREDIT CARD AUTHORIZATION FORM

I _____ (name as it appears on card) authorize the use of my credit/debit card described below for charges related to services provided by Emily Markowitz, LMSW, LCSW.

Credit Card Type: ☐MasterCard ☐Visa ☐American Express ☐Discover

_____

Credit Card Number

_____

Expiration Date CVV Number Billing Zip

_____

Name of Cardholder

_____

Name of Client (if different)

_____

Cardholder Signature Date

I understand the amount charged on my card will be reflected on my credit card statement and the name, Emily Markowitz, LMSW, LCSW (or an abbreviated version) will appear on my credit card statement. _____**(Initial)**

I understand that my card will be kept on file and used to pay for services throughout the duration of treatment unless other arrangements have been made. _____**(Initial)**

I understand that my card will be charged $_____per session and will be charged the full session fee of $_____for missed appointments or late cancellations. _____**(Initial)**

_____

Client or Guardian Signature Date