Dr. Jacquelyn M. Harlan, LMFT
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CREDIT CARD AUTHORIZATION

Please complete the following information:

I, _____, authorize Dr. Jacquelyn Harlan, LMFT to charge
(*print name*)
my credit card for any services rendered as agreed to in the Agreement for Treatment/Informed Consent. I also authorize Dr. Jacquelyn Harlan, LMFT to charge my card in the event I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment at least 24 business hours in advance. Furthermore, for outstanding payments of services rendered, I authorize Dr. Jacquelyn Harlan, LMFT to charge my card for the full amount due. I will not dispute any sessions I have received, or that I have not cancelled less than 24 hours in advance.

I further authorize Dr. Jacquelyn Harlan, LMFT to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

I acknowledge that I am aware there is a $25 fee for any declined credit card charge.

Card Type: Visa _____ Mastercard _____ American Express _____ Discover _____

Card Number: _____ Expiration Date: _____ CID: _____

Name as Printed on Card: _____

Relationship to Patient: _____

Billing Address: _____
(Street, City, State, Zip Code)

Signature: *(patient/financially responsible party)* _____ Date: _____
*Cancellations must be made at least 24 hours in advance or fee must be paid in full and I am aware there is a $25 fee for declined credit cards.

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 24 business hours in advance, or participation in treatment (eg. appointment or phone session) without payment rendered.