CREDIT CARD AUTHORIZATION

Susannah Perkins, LCSW
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Irvine, CA 92618
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Secure patient email: susannahperkins321@gmail.com

Please read and complete the following:

I, the undersigned, authorize Susannah Perkins, LCSW, to charge my credit card for all mental health services rendered through the practice. This includes, but is not limited to, scheduled appointments, appointments missed or not not cancelled with 36 hours prior to visit, time spent addressing clinical matters outside of office visits, and tele-psychiatry. By signing this form, I agree to all the aforementioned terms and conditions. This form will be securely stored in your chart.

NAME ON CARD:_____

BILLING ADDRESS OF CARDHOLDER:_____

CITY/STATE/ZIP:_____

EMAIL ADDRESS (FOR RECEIPTS):_____

TYPE OF CARD (PLEASE CIRCLE): **VISA** **MASTERCARD**

ACCOUNT NUMBER:_____

EXPIRATION DATE:_____

CCV (3 DIGIT CODE ON BACK OF CARD):_____

AUTHORIZED SIGNATURE:

_____ **DATE:**_____