

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I authorize Nicole Dockter LCSW to charge my credit/debit card for professional services as follows:

Please Initial:

_____ Recurring charges for services in the amount of \$_____ per visit.

_____ I understand and agree that my card will be charged full fee for cancellations with less than 24 hours' notice and for appointments I miss without notice.

_____ I understand this form is valid for one year unless I cancel the authorization in writing. I will not dispute charges ("charge back") for sessions I have received or appointments I missed according to the above policy.

I, _____, am authorizing Nicole Dockter LCSW the use of my credit card in the event that I do not notify Nicole of my inability to attend a scheduled therapy appointment and/or do not cancel my appointment at least 24 hours in advance as agreed to in the informed consent form I signed.

Charges will appear on your credit card statement as: Counseling Services.

Card Type (circle one): Visa MasterCard

Card #: _____

Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (3-digit code on back by signature line-MC/Visa) _____

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

Signature: _____

Date: _____

Dates Charged:

Authorization Code:

