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 Weiss 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 Weiss 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 American Express

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:
____________	_______________
____________	_______________
____________	_______________
____________	_______________
____________	_______________
____________	_______________
____________	_______________
____________	_______________
____________	_______________
____________	_______________