lifeworks
PSYCHOTHERAPY CENTER

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Credit Card Authorization

I authorize LifeWorks Psychotherapy Center to keep my credit card information on file and to directly charge my credit card account for:

________ Charges I personally incur for dates of service.

________ Charges I personally incur for appointments cancelled with less than 24 hours notice.*

________ Charges incurred by the following person(s):____________________________________.

Said DOS charges shall be in the form of:

_________ weekly charges of $ ____________________

_________ for ____________ months beginning ______________________________________.

_________ until the patient share of costs (co-pays, co-insurance, deductible) is paid in full.

CREDIT CARD INFORMATION

Credit Card Number ____

Expiration Date ________________________________ 3 Digit Security Code ________________

Card Holder's Name ____

Email ____

Phone Number ____________________________________Zip Code_______________________

Card Holder's Signature ____

Date ____

***Cancellation Courtesy**

The courtesy of 24-hour notice of cancellation of scheduled appointments is requested. Clients will be held responsible for their full session fee, if 24 hour notice is not given to their therapist. Please note your insurance carrier cannot be billed for a cancellation and you will be responsible for the cancellation fee for missed sessions. Insured clients are charged $150 for each missed session.

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