Natalia Tommasi, MA, LPC
971-732-2284

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Credit Card Authorization Form

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 Natalia Tommasi, LPC to charge my credit card for professional services as follows:

Please Initial:

_____ I understand and agree that my card will be charged a fee of $100.00 for cancellations with less than 24 hours notice and for appointments I miss without notice as agreed to in the Client Informed Consent and Disclosure Form I signed.

_____ I understand and agree that my card will be charged for balances of charges not paid by me or my insurance (such as deductibles and copays).

_____ 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.

Charges will appear on your credit card statement as "NTcares".

❑ Visa ❑ MasterCard ❑ American Express ❑ Debit Card ❑ Other

Card #: _____

Expiration Date: _____ Email Address: _____

Name as Printed on Card: _____

Verification/Security Code (the 3-digit code on back of card by signature line):_____

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

_____

Signature Printed Name Date

_____ _____ _____