NICOLE WEISS

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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 (check one): ☐ Visa MasterCard ☐ American Express

Name as Printed on Card: _____

Card #: _____ Expiration Date: _____

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:		Dates Charged:	Authorization Code: