Credit Card Payment Authorization Form

Sign and complete this form to authorize Betsy Giduz, LCSW to maintain your credit card information on file and to post charges to your account for professional services rendered.

Please complete the information below:

I authorize Betsy Giduz, LCSW to charge the credit card account indicated below for services rendered on behalf of _____ on or after the indicated date.

(Patient/Client Name)

Billing Address _____ Phone _____

City, State, Zip _____ E-mail _____

Primary Card

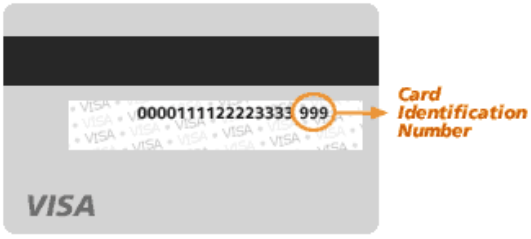
Account Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name _____

Account Number _____ - _____ - _____ - _____

Expiration Date _____ / _____

Card Identification Number (last 3 digits located on back of card) _____



Secondary Card*

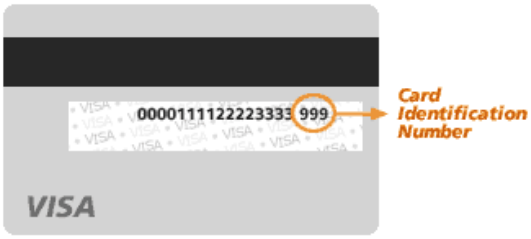
Account Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name _____

Account Number _____ - _____ - _____ - _____

Expiration Date _____ / _____

Card Identification Number (last 3 digits located on back of card) _____



* To be used in the event the Primary Card is declined or otherwise invalid.

I authorize Betsy Giduz, LCSW to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated in this form. I understand this consent will remain in effect until such time as I revoke this authorization in writing to Betsy Giduz, LCSW, and hereby acknowledge that I have the right to do so at any time.

I also acknowledge that it is my responsibility to update the credit card information on file if it subsequently changes.

_____

Cardholder Signature **Date**