

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 and appointments cancelled with less than 24 hours notice.*
_____ Charges incurred by the following person(s):

Said 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.