Heather Luevano MFT

Coastal Family Therapy

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CREDIT CARD AUTHORIZATION

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request.

I_____, am authorizing Heather Luevano, MFT to use my credit card information to charge my credit card in the event that:

_____I do not notify her of my inability to attend a scheduled therapy appointment

_____I do not cancel my appointment at least 24 hours in advance

($75.00 late fee will apply)

_____A check is returned for any reason **(an additional $35.00 fee for returned checks)**

_____There is an outstanding balance after 30 days from the date of services rendered

_____I am electing to use this card for co-pay fees for services rendered

Type of Card: VISA MASTERCARD DISCOVER

Card Number:_____

Verification / Security Code:_____Exp. Date:_____/_____

Billing Address of Card Holder (if different than patient):

_____

_____

Patient Name:_____

Cardholder Name (If different than Patient):_____

Cardholder Signature_____Date_____