Credit Card Authorization Form

I authorize for Jessica Dubin LCSW to place my credit card information on file for the purposes of payment. I also authorize for Jessica Dubin LCSW to charge the card after each service provided, including no-show appointments, as indicated in the signed treatment agreement.

It is my responsibility to update my records should my credit card be cancelled or expire. And in the event a card is declined or has insufficient funds, I will still be responsible for payment. I agree not to dispute charges for services that I have received, or that I have not cancelled with appropriate notice.

Patient Name

Cardholder Name (if different)

Cardholder Billing Address (including city, state and zip code)

Credit Card Number

Expiration Date

CVV

Cardholder Signature

Date