CREDIT CARD PAYMENT AUTHORIZATION

Client Name _____ **DOB** _____

I authorize *Campbell Psychological Services LLC, 25 East North Street, Carlisle, PA 17013,* to charge my credit/debit card on file for professional services as follows:

- Session fee or co-pay/co-insurance, to be charged after each appointment.
- Fees incurred for missed appointments and appointments cancelled with less than 24 hours' notice. Card is charged the same day. (As of Jan 1, 2020, fee is $60 per missed / late cancelled appointment. Fee is subject to change with notice.)
- Any outstanding balance due including, but not limited to, balance due to insurance deductible, lapse in insurance coverage, or services not covered by insurance.

I understand my card will be kept on file and charged as described above.

Card Holder Name (print)_____

Last 4 Digits of Card ____ ____ ____ ____

Card Holder Signature _____ Date _____

Charges will appear on your credit card statement as ***Campbell Psych Svcs***