LifePoint child and family therapy

495 N. Riverside Dr., Ste 208, Gurnee, IL 60031
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LifePointTherapy.com

Credit Card Authorization Form

Please complete all fields. This authorization will remain in effect until cancelled in writing.

Client Name(s):

_____ and _____

Last Four Digits of CC Number:_____

By signing below, I authorize *LifePoint Child & Family Therapy LTD* to charge the credit card named above for agreed upon service and cancellation fees. I understand that my information will be saved on file with encryption to our electronic health record for future transactions on my account. After card is entered electronically, the bottom portion of this form will be destroyed. I also understand that unless otherwise agreed upon, fees are collected on the date of service.

CANCELLATION POLICY REVIEW

- FULL SESSION FEE IS CHARGED FOR MISSED, CANCELLED, OR CHANGED APPOINTMENTS WITH LESS THAN A 48-HOUR NOTICE UNLESS IT IS DUE TO SERIOUS ILLNESS OR AN EMERGENCY.
- IN THE CASE OF SERIOUS ILLNESS OR EMERGENCY THERE IS A $40 FEE FOR CANCELING.
- ANY FEES WILL BE CHARGED ON THE DAY OF THE MISSED APPOINTMENT.
- WORK OR SCHOOL ACTIVITIES DO NOT COUNT AS AN EMERGENCY.

Cardholder Signature_____Date_____

Credit Card Information	
Card Type	☐Master Card ☐ VISA ☐ Discover ☐ AMEX and HSA or FSA? Y N
Cardholder Name (as shown on card)	
Billing Address, Zip	

(please remove and destroy information below after entering into EHR)

Card Number	
Expiration Date and Security Code	Exp (mm/yy) ——-/——- Security Code (3 digits): _____

[Rev 3.20]