The Office of

Barbara E Doak, LCSW, LLC

Credit or Debit Card Payment Consent

Client Name: _____

Card Holder Name: (If different from client) _____

Card Type (MasterCard/Visa): _____

Card Number: _____

Expiration Date: _____ 3 digit CCV# on back of card: _____

Billing Zip code: _____

I authorize the office of ***Barbara E Doak, LCSW, LLC*** to keep the above card information on file and charge my credit/debit or HSA card for professional services resulting in any co pays, coinsurance or deductibles due on my account. I further agree that a transaction fee of 3% will be added to this charge, if applicable.

If I do not cancel 24 hours in advance of my scheduled appointment time, I recognize that ***Barbara E Doak, LCSW, LLC*** will charge my card $75 for any missed appointment fee, if applicable.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred.

_____ Date: _____

Client Signature

_____ Date:_____

Card Holder Signature (If different from client)