CC Authorization Form

I authorize Jennifer Fairchild, LCSW to charge my credit/debit card for professional service rendered as follows:

Please initial:

___________I agree that I will be charged a full session fee for any missed sessions with less than 24 hours notice.

__________I agree that any unpaid copayments, deductibles and session fees denied by your insurance company will be automatically deducted from your card.

__________I agree to not dispute charges ("charge back") for outstanding balances or appointments I missed according to the above policy.

I have read and understand the credit card authorization agreement and authorize Jennifer Fairchild, LCSW to charge my credit card as stated as above.

Card holders Signature: ____Date:_____________________________________

Number: ____Expiration Date:____________________________________

Verification/security code (3 digit code on back of card):____

Zip Code:____

Email address you will like your receipts send to:____