Patrick McKee, LCPC

Individual, Family and Group Psychotherapy for Children, Adolescents and Adults

Credit Card Authorization Form

Please complete the following information. This form will be securely stored and may be updated upon request at any time.

In case of late cancellations and/or no show for scheduled sessions, or if a check is returned unpaid, you will be charged the full session fee. An additional $30 is assessed for returned checks. There is no refund for services rendered.

I, _____, authorize Patrick McKee, LCPC to use the information below to charge my credit card in the event:

- **I do not attend a scheduled therapy appointment that I have not cancelled at least 24 hours in advance,**
- **I have my check returned to Patrick McKee, LCPC for any reason, or**
- **I do not pay any balance due to Patrick McKee, LCPC left by myself or my insurance company within 30 days from the date on the invoice.**

Card Type *(circle one):* Visa MasterCard Discover American Express

Card #:_____ **Expiration Date**:_____

Name as Printed on Card:_____

V**erification/Security Code *(code on back of card by signature line)*:**_____

My Billing Address *(where my credit card statements are sent):*

Address:_____

City:_____ State: _____ Zip:_____

Signature:_____ Date:_____

By signing below, I authorize Patrick McKee, LCPC to charge my credit card on an ongoing basis for scheduled appointments.

Signature:_____ Date:_____

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