LISA KREUTZBERG, MS., LPC.

BEACH COUNSELING LLC

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732-305-4532

CREDIT CARD AUTHORIZATION

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

I authorize Lisa Kreutzberg to charge my credit/debit card for professional services as follows:

Please initial:

_____ Charges per service in the amount of $150/$175 (initial) per visit.

_____ I understand and agree that my card will be charged $150 for cancellations with less than 24 hours' notice.

_____ I understand that this form is valid for one year unless I cancel the authorizations in writing. I will not dispute charge for sessions I have received or appointments I missed according to the stated policy.

_____ When using my health insurance to pay for therapy, I am responsible for any co-pays, deductibles, and co-insurance. If for whatever reason, claims are denied, I am responsible for the fees owed. Health insurance never pays for late cancel or no-show appointments. I will be responsible for the fee for service in the event of a late cancel.

Card Type (circle one): Visa Mastercard American Express

Card Number:_____

Exp Date:_____ Security Code:_____

Name as Printed on Card:_____

Billing Address for Card: _____

Phone Associated with Card:_____

Signature:_____Date:_____