Jill R. Stevens, M.A. **Licensed Clinical Professional Counselor**

(618) 713-5672 **www.jstevens.info** **1110 N. Washington St.**
Naperville, IL 60563

Credit Card Authorization Agreement

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

In the case that you miss or fail to cancel an appointment within 24 hours of the scheduled time, or if a check is returned unpaid, you may be charged up to the full session fee.

I, ___________________________________, authorize Jill R. Stevens, M.A., LCPC to use my credit card information to charge my credit card in the event that I do not notify her of my inability to attend schedule therapy appointments and/or do not cancel my appointment at least 24 hours in advance, or if a check is returned for any reason. I also authorize her to charge my credit card for session fees, including self-pay, copays, and/or coinsurance. I will not dispute charges ("charge back") for sessions I have received or appointments I have missed according to the above policy.

Card Type (circle one): VISA MasterCard Discover American Express HSA FSA

Card #: ____________________________________ Expiration Date: _______________

Name as Printed on Card: ____

Verification/Security Code (3 digit code on back of card by signature line): ____________

Billing Address: ____

City: _______________________________ State: ____________ Zip: _______________

Phone: ________________________ Email: _____________________________________

By signing below I am authorizing Jill R. Stevens, M.A., LCPC to charge for scheduled and missed appointments.

Signature: ____________________________________ Date: _______________________