

Therapist: \_\_\_\_\_

### CREDIT/DEBIT CARD AUTHORIZATION FORM

Lake Orion Counseling Center requests that all patients have a card on file for payment of patient responsibility at the time of service. This assists in the collection of payments due at the time of service and balances that accrue. Account numbers are kept secure. Charges and fees are described in the Benefits Inquiry and Informed Consent.

I authorize Lake Orion Counseling Center to process payments to my credit/debit card for all balances that may accrue for sessions. This includes costs of sessions, copays, co-insurance, phone consultations, report writing, no show charges, etc.

Client Name \_\_\_\_\_ DOB \_\_\_\_\_

Cardholder Name \_\_\_\_\_ DOB \_\_\_\_\_

Card Number (16 digits) \_\_\_\_\_ Expiration Date \_\_\_\_\_

VCode \_\_\_\_\_

Type of Card    Visa \_\_\_\_\_    MasterCard \_\_\_\_\_    Discover \_\_\_\_\_    Amex \_\_\_\_\_

Credit Card Billing Address \_\_\_\_\_

City \_\_\_\_\_    State \_\_\_\_\_    Zip Code \_\_\_\_\_

Email address for credit card receipts: \_\_\_\_\_

Signature of cardholder/guarantor \_\_\_\_\_

Date \_\_\_\_\_

Please direct questions to the billing service at: 630-791-8025 or Lake Orion@PremierMBS.com