

Marie D. Guillory, M.Ed., LPC, RTC
5822 91st St
Lubbock, Texas 79424

Phone: (806) 939-5673 www.mdgcounseling.com Fax: (806) 798-0823

CARD AUTHORIZATION FORM

CLIENT NAME: _____

DATE OF BIRTH: _____

The purpose of this form is to authorize Marie D. Guillory, LPC to retain a valid credit/debit card number on file for you as our client. All new clients are required to complete this form. This form will be kept confidential and only authorized staff will have access to the information.

Your supplied credit/debit care will be charged ONLY under the following circumstances:

1. Marie D. Guillory, LPC reserves the right to charge the credit/debit card listed on page 2 for all current clients balances, including co-pays. A receipt will be kept in your client chart, unless directed to send the receipt directly to you. This notice serves as your consent to being charged for all current client balances on your account.
2. If you, as the client, miss a scheduled appointment without 24-hour notice to cancel or reschedule, Marie D. Guillory, LPC reserves the right to charge the credit/debit card listed on page 2 \$135.00 for our standard no-show fee. A receipt will be sent to the current address file. This notice serves as your consent to being charged for any and all no-shows.
3. If we receive notice that a payment is returned to us for any reason, Marie D. Guillory, LPC reserves the right to charge the credit/debit card listed on page 2 a \$25.00 returned check fee as well as the amount of the issued insufficient check. A receipt will be sent to the current address on file. This notice serves as your consent to being charged for any returned payments.
4. Other than the conditions mentioned above, under NO circumstance will Marie D. Guillory, LPC charge your credit/debit card for anything not discussed personally with you. In conjunction with HIPAA regulations, all credit/debit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed & Accepted:

My signature below acknowledges that I have read this form, and give my authorization and consent to provide the requested information --on page 2-- for my credit/debit card to be charged for the conditions listed above, plus a Card Convenience fee of approximately 5%.

Client or Responsible Party - Signature

Date

Counselor Signature

Date

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NAME, AS IT APPEARS ON CARD: _____

DEBIT or CREDIT: _____

BILLING ADDRESS: _____

AMEX/DISC/MC/VISA CARD#: _____

EXPIRATION DATE: ____/____

VERIFICATION CODE (3 or 4 DIGITS): _____