

Credit Card Authorization Form to Kurt LaRose MSW LCSW

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Credit Card Billing Authorization	
Credit card billing authorization is provided to Kurt LaRose MSW LCSW	
Person Authorizing And the Name on Card:	
Credit Card Type:	Visa [<input type="checkbox"/>] MasterCard [<input type="checkbox"/>] Discover [<input type="checkbox"/>] *** PROFESSIONAL/COMPANY CARDS WILL BE CHARGED A \$21.00 USAGE FEE
Issuing Bank:	
Credit Card Number:	
Enter CVC (Security Code):	
Expiration Date:	
Billing Address:	
City:	
State:	
Zip/Postal Code:	
Okay to Email Receipts?	[<input type="checkbox"/>] YES [<input type="checkbox"/>] NO
Personal Email Address:	
Phone Number:	
Fax Number:	
Please select, with an "X", one of the Following Payment Options:	

[] Bill my credit card for each session** at the appropriate rate per hour, up to and including present and future balances**

**This check ('x') authorizes and enables repeat billing, including no show fees; re-imbursments/adjustments will be made with health insurance payments after EOB's and payments have been made, as explained in all of the Practice Terms and Policies signed elsewhere and incorporated here by reference.

Card Applicant agrees with the "authorized signature" below, that all information provided is accurate and complete. **Applicant acknowledges** that services may be terminated at LaRose's discretion if charges are declined or charge-backs are claimed. **Applicant grants authorization** to LaRose to use third party billing agents to process and collect unpaid charges, declined charges, and/or chargebacks. **Applicant agrees** that some protected health information may be released to fulfill the terms of this authorization (information that will be released to charge, bill, or collect includes ONLY: use of services, session attendance and time, and 24 hour non-cancellation fees).

Disputes to amounts invoiced, and any changes and updates to the status of this card should immediately be reported to [Kurt LaRose MSW LCSW](#) at OF: 850-765-5206 or CL: 850-545-2886.

*** If using a company card, please indicate that the undersigned is a duly authorized representative of (company name) _____ (additional fees will apply)

Authorized Cardholder Signature: _____ Date: _____

*Client: _____ Date: _____

*Client Signature (necessary in scenarios where a party other than the client is making payments on behalf of the client), acknowledging and granting the release of information to the paying party named herein, regarding attendance/no shows/third party out of pocket fees, associated thereto.