

# CREDIT CARD PRE-AUTHORIZATION

## For Use By Lori Bergstrom, LMFT and BrainWellnessPRO.com.

I authorize Lori Bergstrom and BrainWellnessPRO.com to keep my signature on file and to charge my account for:

Payment of my session in the amount established by my provider:

\_\_\_\_\_ (Amount/50 min)

\_\_\_\_\_ (Amount /75 min)

\_\_\_\_\_ (Amount /90 min)

\_\_\_\_\_ (Amount /120 min)

- This visit only
- Every visit, unless I request to pay by another method at the time of service
- A Block of Sessions - specify quantity of sessions: \_\_\_\_\_
- Past Due Sessions
- Late Cancellations and No Shows – billed at 50% of established fee

I understand that my card will be charged only in the event that I fail to provide payment in full by check or cash at the time of my session. I will be notified, verbally, by my provider that the past-due payment for my session will be applied to my credit card, unless usual billing arrangements are stipulated above.

I understand that this authorization form is valid for 4 years unless I cancel the authorization through a written notice to my health care provider, named above.

Clients Name: \_\_\_\_\_

Card Holders Name: \_\_\_\_\_

Card Holders Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

- Visa
- Mastercard
- Amex
- Discover

Acct. # \_\_\_\_\_ CSC # \_\_\_\_\_

(3-digit # on back of card)

AMEX Holders, add 4 digit code \_\_\_\_\_

Signature: \_\_\_\_\_

Ex Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_