

**Briana Evans, LCSW** LCS # 22041

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Licensed Clinical Therapist

OCD \* Anxiety \* Behavior Issues

### **Credit Card Authorization Form**

In order to best serve my clients and to simplify the billing process, Briana Evans, LCSW requires that a credit card or Health Saving Account (HSA) card be held on file in our HIPAA compliant, encrypted program. The card will be automatically charged for services rendered as well as missed or late canceled appointments, as outlined in the Consent for Treatment Agreement. Receipts will be emailed on a monthly basis but can be requested sooner.

Client's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

#### **Credit Card Information**

Card Type: \_\_\_\_\_

Card Holder Name: \_\_\_\_\_

Card/Account Number: \_\_\_\_\_ Exp Date: \_\_\_\_\_ CVV Code: \_\_\_\_\_

Address on Card: \_\_\_\_\_  
\_\_\_\_\_

By signing this form I authorize Briana Evans, LCSW and/or her contracted billing company to keep my credit card or (HSA) information on file and to automatically charge the credit card/(HSA) card I provide for any outstanding balance on an ongoing basis until or unless I cancel these automatic payments in writing.

I understand charges will be made for services rendered and for missed or late cancelled appointments as stated in the Consent for Treatment Agreement.

I understand that I am responsible for notifying Briana Evans, LCSW or her contracted billing company and providing a working new credit card/(HSA) information whenever the current credit card/HSA information is no longer valid or usable for any reason.

I certify that the above information is true and accurate and that I am an authorized user on the provided credit card/(HSA) account.

Card Holder

Signature \_\_\_\_\_

Date: \_\_\_\_\_