Sharon G. Richardson, LCSW-C-Psychotherapeutic Services

DEBIT CARD AUTHORIZATION FORM

All information will remain confidential.

Client Name: ____ DOB: _________________

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Name on Card: ____

Billing Address: ____

_____________________________ **Billing Zip CODE: ______________________**

Debit Card Type: _____ Visa _____ Master Card

Debit Card Number: ______________-______________- _______________-_____________

Expiration Date: _________/_________ 3-digit code (on back of card): ______________

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Amount to be charged:

- **Session rate + 5% debit authorization fee;**
- **For full session rate where the patient does not cancel within 24 (business) hours of appointment, or that which the patient misses/no-shows; and/or**
- **Balance due for any session(s), or in part of, for which insurance does not reimburse**

I authorize Sharon Richardson to charge the agreed amount listed above to my debit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

I understand that paying for the above-named client's appointments does not entitle me to any therapeutic information from Sharon Richardson, LCSW-C.

To obtain any information from Sharon Richardson, LCSW-C, the above patient would have to agree, through signing a Confidentiality Release of Information form.

Cardholder – Please Print Name, Sign and Date Below:

Printed Name: ____

Signed: ____

Dated: ____