ELECTRONIC PAYMENT AUTHORIZATION

Please provide a credit or debit card that would *only be used* by Amy L. Kopel, LLC if

I, _____ (the person legally responsible for payment), fail to pay Co-payments, leave counseling with an unpaid balance and/or miss appointments without 24 hours notice and do not return to pay the missed appointment fee. I understand that if Amy L. Kopel, LLC has to use this credit card she will charge an additional $1.50 to cover her costs for using a credit card service.

Client Information

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Number: _____ Mobile Phone: _____

Email: _____

Billing Information

Please indicate the information associated with the credit/debit card.

Name on card: _____

Address if different from above: _____ City: _____

State: _____ Zip: _____

I, (full name) _____ understand that this form authorizes my provider to charge this card only under the conditions as outlined above for the dates involved. *By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes payment under the conditions outlined.

_____ _____

Card Holder Signature Date

Card Information

Please provide your payment information below.

Card (circle one): Visa Mastercard Discover American Express

Card number: _____ CVV code (three digits on back of card) _____

Expiration Date: _____