Beth Friedman, LCSW, MPH
51 West 86th Street, Suite 104A. New York, NY 10024
917-400-9595 * BethFriedmanLCSW@gmail.com
www.NYCTherapistBeth.com

Credit Card Authorization Form

Please note that this form will be securely stored in your clinical file and that you are willing to assume the risk for keeping this information on file.

I authorize Beth Friedman, Licensed Clinical Social Worker (License Number R054706) to keep my signature and credit card information on file and to charge scheduled therapy session fees (individual, groups, workshops, couples, family or other). In accordance with office policy, sessions that are cancelled with therapist Beth Friedman, LCSW less than 24 hours before the scheduled appointment time, unless previously agreed upon, are billable and may automatically be charged.

_____

(Therapy client's name: Please Print)

I understand that this authorization is valid until canceled in writing. I understand that though this information is secured in my client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I agree that the card listed below may be charged by Beth Friedman, LCSW in order to settle any outstanding balances accrued by the above listed client. I understand that if a charge back fee is incurred, I am responsible for that fee. **Initial**_____

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Beth Friedman, LCSW for any assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Beth Friedman, LCSW and those attempts have failed. **Initial**_____

Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by Beth Friedman, LCSW. **Initial** _____

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Credit Card Authorization Form (continued)

_____

(Therapy Client's Name: Please Print)

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Signature:_____

Cardholder Name (Print):_____

Relationship to Client:_____

Card Type (circle one): Visa Mastercard Discover American Express Flex/HSA

Card Number:_____

Expiration Date:_____ Security Code (3 or 4 digit):_____

Credit Card Billing Address: Street:_____

City:_____State:_____Zip Code:_____

Telephone Number:_____

I understand that my therapy session will be charged via this form and not by swiping my card to collect fees for services rendered or for cancellation fees.

Cardholder Signature:_____

Date:_____