**Cassie V. Comeau, Ph.D.**

**114 Village Place, Suite 203**

**Dillon, Colorado 80435**

**Credit/Debit Card Authorization Form**

Many clients prefer to pay for sessions using a credit or debit card. By completing this form you are providing consent for Dr. Comeau to charge the card listed below to pay for our sessions. In case of late cancellations and/or no-shows to scheduled sessions, or if a check is retuned unpaid, you will be charged the full session fee. An additional $25 is charged for all returned checks. **If you do not wish to pay for sessions using the card listed below, please discuss alternative payment options with Dr. Comeau immediately.**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Cassie V. Comeau, Ph.D. to use my credit/debit card information to charge my credit/debit card in the event that I do not notify her of my inability to attend a scheduled therapy appointment, do not cancel my appointment with at least 24 hours advance notice, or if a check is returned for any reason as agreed to in the Fee Disclosure and/or Psychotherapist/Patient Services document(s).

**Please Print Clearly**

Card Type, please circle: Visa MasterCard Discover AMX

Card Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code\_\_\_\_\_\_

Name as printed on card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

By signing below I am authorizing Cassie V. Comeau, Ph.D. to charge the above card for scheduled appointments. My signature also indicates that I will inform Dr. Comeau of any changes to this billing information over the course of our work together.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature Date