Miki Johnston, MSW, LCSW
email@mikijohnstontherapy.com

**CREDIT CARD AUTHORIZATION FORM**

I, ____________________________________________ authorize the use of my credit/debit card described below for charges related to services provided by Miki Johnston, MSW, LCSW.

Initial each of the following statements:

______ I understand that my card will be charged $175 per session throughout the duration of services.

______ I understand that my credit card will be charged for telephone consultations exceeding 15 minutes. These charges will be prorated based on the fee of $175.

______I understand I will charged the full session fee of $175 for missed appointments or cancellations not made at least 24 hours in advance.

_______ I understand all credit card information is confidential and will be kept in a secured location and destroyed upon the completion of services.

______ I understand if my credit card is declined for any reason, I am responsible for immediate payment of the full balance by cash or check.

Client or Guardian Signature ______________________________________ Date ____________

☐ Mastercard ☐ Visa ☐ American Express ☐ Discover

Name as it appears on card: _________________________________________

Credit Card #:_______________________________________________________

CCV: __________________ Expiration Date: __________________________

Billing Address: ______________________________________________________

______________________________________________________

Email address ______________________________________________________

Cardholder signature: _______________________________________________