



Heather Luevano MFT

Coastal Family Therapy

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CREDIT CARD AUTHORIZATION

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request.

I _____, am authorizing Heather Luevano, MFT to use my credit card information to charge my credit card in the event that:

_____ I do not notify her of my inability to attend a scheduled therapy appointment

_____ I do not cancel my appointment at least 24 hours in advance

(\$75.00 late fee will apply)

_____ A check is returned for any reason (**additional \$35.00 fee for returned checks**)

_____ There is an outstanding balance after 30 days from date of services rendered

_____ I am electing to use this card for co-pay fees for services rendered

Type of Card: VISA MASTERCARD DISCOVER

Card Number: _____

Verification / Security Code: _____ Exp. Date: _____ / _____

Billing Address of Card Holder (if different than patient):

Patient Name: _____

Cardholder Name (If different than Patient): _____

Cardholder Signature _____ Date _____