Megan Earles, LCSW, LLC

PHONE (941) 564-3018
FAX (941) 296-7254

Credit Card Authorization Form

_____ _____
Client's Name (Please Print) Date of Birth

_____ _____
Cardholder's Name (Please Print) Relationship to Client

_____(initials) I authorize all charges incurred at Megan Earles, LCSW, LLC, according to the agreed upon fee schedule. I understand that my card will be charged at the date and time the service is provided.

_____ (initials) I authorize the credit card below to be kept on file for the duration of treatment for the above named client or until I have provided written notice of withdrawal of my authorization.

Please Circle One: Mastercard ☐ Visa ☐ Discover ☐

Please Circle One: Credit ☐ Debit ☐ HSA ☐

Name on Card: _____

Card Number: _____

Expiration Date: _____ **Security Code:** _____

Billing Address: _____

Choose one of the following: ❑ No receipt required ❑ Give receipt to client

I understand that I must contact the billing department to make any changes to this authorization.

_____ _____
Cardholder's Name (Please Print) **Phone Number**

_____ _____
Cardholder's Signature **Date**

_____ _____
Client Signature (If minor, parent or guardian signature) **Date**