JOYCE BABB, LCSW CREDIT CARD AUTHORIZATION FORM

I authorize JOYCE BABB, LCSW to process payments on my credit card for services and fees, which may include co-payments, co-insurances, deductibles, account balances, missed appointments/no show/late cancellations, non-insurance plan covered services, and other amounts owed.

I understand that I may opt to pay by cash, check, or to defer to the credit card on file. I also understand that I may revoke my credit card by informing Joyce Babb, LCSW.

This information as well as my signature will serve as my authorization for Joyce Babb, LCSW to charge my credit card for any balance determined to be my responsibility.

Card Type (Circle one) Visa MasterCard. Discover

CARD HOLDER INFORMATION

Full Printed Name on Credit Card_____

Credit Card Number_____

Credit Card Billing Address_____

City_____State_____ Billing Zip Code_____

Expiration Month_____/ Year_____. 3 Digit Security Code _____

Card Holder Signature _____ Today's Date_____

Billing Email Address_____

Please Print Name and Birthdate For All Other Clients Utilizing This Credit Card Account

Name_____. Birth Date_____/_____/_____

Name_____Birth Date _____/_____/_____