Breakthrough Therapeutic Concepts, LLC.

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Attending Psychologist: Dr. Deondra L. Smith

CREDIT CARD AUTHORIZATION FORM

I authorize my provider (**Deondra L. Smith, PsyD)**, to keep my signature on file and charge my credit card for payment of my session in the amount established by my provider for the following purposes:

- ☐ For a No-Show or missed session without a 24-hour cancellation notice
- ☐ For session cost (if self-pay client)
- ☐ For a phone session (if applicable)
- ☐ Other _____

I understand that my card will be charged 50% of the session cost only in the event that I fail to provide sufficient notice of cancellation at the time of my session. I will be notified by my provider that the missed session.

I also understand that if I want to use my credit card for my session(s) that I will make a payment at the beginning of the session using the physical credit card.

Please note, if a credit card is used for payment at the time of the session or for any of the reasons mentioned above, a $6.00 service fee will be added to the cost of the session.

I agree that this form is valid for the length of therapy and authorization for the use of this card will be cancelled at the termination of therapy.

Client's Name: _____
Card Holder's Name: _____
Card Holder's Address: _____
City: _____ State:_____ Zip: _____
Phone: _____ Email: _____
☐ Visa ☐ Master Card ☐ American Express Acct. # _____
CSC#_____ (3-digit # on back of card)
Signature:_____ Exp. Date: ____/ ____/ ____