

## Credit Card Authorization

Name as it appears on credit card \_\_\_\_\_

Billing address for credit card:

Street address or PO Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Type of card (circle): VISA / MasterCard / Discover / American Express

Credit Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_  
Month Year

Three or four digit verification/security code on back of card: \_\_\_\_\_

I hereby authorize Sheila K. Bost, LMFT to charge my credit card on the following basis (please indicate selection):

\_\_\_\_\_ One-time charge in the amount of \$ \_\_\_\_\_

\_\_\_\_\_ Recurring charges as services are provided

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient or person financially responsible

I, the undersigned individual, authorize Ms. Bost to charge my credit card in the event that I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify Ms. Bost at least 24 business hours in advance for a cancelled appointment, as agreed to in the Office Policies and Treatment Consent Form.

Furthermore, for outstanding payments of services rendered, I authorize Ms. Bost to charge my credit card for the full amount due. I agree to not dispute charges for any of these reasons. I further authorize Ms. Bost to disclose information about my attendance and/ or cancellation to my credit card company if I dispute a charge. This form will be securely stored in your clinical file and may be updated upon request at any time.

\*Please note, your credit card will not be charged unless one of the following conditions apply: (a) no-show for a scheduled appointment, (b) cancellation less than 24 business hours in advance, or (c) participation in treatment (e.g., appointment or phone session) without payment rendered.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient or person financially responsible

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