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 Polices 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

Sheila K. Bost, LMFT, MFC 47175
3201 Wilshire Blvd.
Suite 201
Santa Monica, CA 90403
310.317.1615
bostlmft@gmail.com

www.sheilakbost.com