

Eveline Smilack, MFA, LMFT
Licensed Marriage & Family Therapist #91090
Practice of Psychotherapy

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CREDIT CARD CONSENT & AUTHORIZATION FORM

I, _____, hereby authorize Eveline Smilack, MFA, LMFT to keep my signature on file and to automatically charge my credit card account for any and all of the reasons indicated below:

- Charges for missed or cancelled sessions, with less than 24 hours advance notice, from ___/___/___ until Patient (named below) is formally discharged as a patient from the office of Eveline Smilack, MFA, LMFT, unless I revoke such authorization in writing beforehand. An additional 3% will be added to missed/cancelled session fee, per charge.
- Charges for the amount of each check that does not clear the bank, for whatever reason, plus a \$25 returned check charge per incident.

I, _____, also authorize Eveline Smilack, MFA, LMFT to automatically charge my credit card account for each of the selected reasons below:

- A single charge of _____ for Client's initial session on ___/___/___ .
- Recurring charges (ongoing treatments) per visit of _____ from ___/___/___ until Client is formally discharged as a client from the office of Eveline Smilack, MFA, LMFT, unless I revoke such authorization in writing beforehand.

CREDIT CARD INFORMATION

Client Name: _____

Cardholder Name : _____ (As Printed on Card)

Account #: _____

Expiration Date: _____/_____/_____

Card Type: VISA / Mastercard /American Express (Circle One)

V Code: _____ (VISA / Mastercard - 3 digits on back /American Express - 4 digits on front)

Card Holder Address

Street: _____

City : _____

State & ZIP CODE: _____

Email Address: _____

Card Holder Signature: _____