

Credit Card Payment Consent Form

Name \_\_\_\_\_  
Print Last First Middle Initial

Name on Card if different: \_\_\_\_\_

I authorize Naomi Clark Babcock LCSW and those employed by Naomi to charge my credit/debit card for professional services as follows:

Initial

\_\_\_\_\_ All visits for which payment/co-payment is not made at the time of the visit (including deductibles and co-insurance).

\_\_\_\_\_ To charge my card for the balance of fees not paid by insurance company within 90 days of the billed visit.

\_\_\_\_\_ To charge my card for \$50 for each no-show or cancellation in less than a 24 hour period (one grace miss will apply and be tracked) with no exceptions thereafter as it is difficult to evaluate each reason individually and the timeslot of 50 min. is reserved for exclusively for you.

\_\_\_\_\_ To charge my credit card for responses to e-mails or phone calls discussing clinical issues (first 10 minutes are free of charge).

Type of Card): \_\_\_\_\_  
(accept Visa, Mastercard, and Discover

Credit Card Number: \_\_\_\_\_

CVV Number: \_\_\_\_\_

(3 digit number on the back)

Expiration Date: \_\_\_\_\_ Current Zip Code: \_\_\_\_\_

Card Holders Signature: \_\_\_\_\_

**\*please note that any information provided herein will be kept in a locked filing cabinet and all employees must abide by rules of confidentiality of sensitive information disclosed.**