Authorization to Secure Payment Form

Client's Name: ____

Date:_____________________________ Client's DOB: ____________________________________

Client's Address: ____

I authorize Dr. Aimee Koerner-Frank, PsyD/Vine Counseling Center, LLC to process payment on my Visa, MasterCard or Discover Card for any balance due that has not been paid for 30 days after it was accrued. I understand that I have given Dr. Aimee Koerner-Frank, PsyD/Vine Counseling Center, LLC my credit card information to keep securely on file. I understand if an appointment is missed and I do not follow the cancellation policy (Missing a scheduled appointment or fall to provide 24 hour notice.) as specified by Dr. Aimee Koerner-Frank, PsyD/Vine Counseling Center, LLC is authorized to charge my credit card the same day as the missed appointment. I understand that if my card is declined Dr. Aimee Koerner-Frank, PsyD/Vine Counseling Center, LLC may put my credit card payment through on another day when funds become available.

I have read and understand this form. I attest that the information below is true and accurate.

My Credit Card Information Is As Follows:

Cardholder's Name As It Appears On The Card:____

Address Associated With The Card:____

Credit Card Number: ____

Master Card: ___________ Visa: _____________ Discover Card: ____________ Other: _______________

CVV Number: ______________________ Expiration Date: ___________________

Printed Name of Cardholder: ____

Client/Cardholder Authorized Signature: ____

By providing the following e-mail address, I give Dr. Aimee Koerner-FRank, PsyD/Vine Counseling Center, LLC authorization to communicate with me/and or submit a bill to the email address listed below. I also understand that by providing the following e-mail address, I accept the HIPPA risks associated with electronic submission of data.

E-mail address: ____