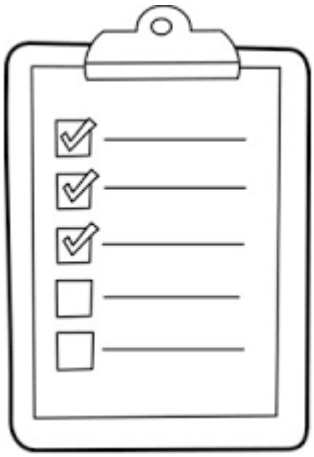

CAMILLE HOLINER, PsyD.

WELCOME

We strive to provide quality, comprehensive care to children, adolescents and adults.

Date:_____

Acct.#:_____

Patient information

Patient Name:_____s_____
Last First Middle Initial Preferred Name (nickname)
SS#:_____-_____-_____ Gender: F M Date of Birth:_____/_____/_____ Age:_____
Home Address:_____Apartment #_____
_____
City State Zip Code
Primary Phone: (___)_____type:_____
Alternate number: (____)_____type:_____

Email Address: _____

Marital Status: Single Married Divorced Separated Widowed
Race: White Black Hispanic Native American Other: _____
Ethnicity: _____

Employed: Yes No Student: Yes No
Employer: _____Occupation:_____
Address:_____
Wk. Phone: (____)_____x_____
May we contact you by phone for appointment reminders? Primary phone: Yes No Work: Yes No

Additional Contact Information

Emergency Contact: _____
Phone: (____)_____ Relationship to Patient:_____

Referral Source:_____
Specialty:_____ Phone: (____)_____
Address:_____

☐ Please check this box if you **DO NOT** want a copy of your evaluation sent to the referral source you have listed above.

Spouse's Name:_____ Spouse's Date of Birth:_____/_____/_____
Last First
Spouse's Employer:_____
Spouse's Work Phone: (____)_____x_____ Spouse's SS#: _____-_____-_____

Is patient under the age of 18? Yes No

IF YES, PARENT / GUARDIAN MUST FILL OUT
IF NO, PLEASE STOP HERE AND SIGN THE BOTTOM.

Parent Name:_____ Date of Birth: _____/_____/_____
Last First

Address: _____SS#: _____-_____-_____

City: _____ State: _____ Zip_____ Home Phone: (____)_____

Employer: _____ Work Phone:

(____)_____x_____ Relationship to patient: _____

_____ _____
Signature of Patient / Parent / Guardian Date

THANK YOU FOR CHOOSING US FOR YOUR CARE.

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/ OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE
CAMILLE HOLINER, PysD.

Primary

Carrier Name: _____

ID#: _____

Group Name / Number: _____

Policy #: _____

Ins. Co. Phone #: (____)_____

Insured Party Information (**If other than Patient**):

Name: _____

Date of Birth: _____/_____/_____

Address: _____

SS#:_____-_____-_____

Insured's Employer: _____

Relationship to patient: _____

Medicare Supplement/Secondary

Carrier Name: _____

ID#: _____

Group Name / Number: _____

Policy #: _____

Ins. Co. Phone #: (____)_____

Insured Party Information (**If other than Patient**):

Name: _____

Date of Birth: _____/_____/_____

Address: _____

SS#:_____-_____-_____

Insured's Employer: _____

Relationship to patient: _____

I hereby assign and convey directly to the above- named health care provide, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies and/or medications rendered or provided by the above- named healthcare provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefits payments. I hereby authorize the above-named healthcare provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named healthcare provider any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys to order to claim such medical benefits.

In addition to this assignment of medical benefit and/or insurance reimbursement above, I also assign and/or convey to the above-named healthcare provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance, or tortfeasor insurance concerning medical expenses incurred as a result of medical services, treatments, therapies and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies and/or medications provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims) .The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) makes statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THE AGREEMENT.

_____ _____
Patient signature (Parent /Guardian's signature if patient is under 18) Date

_____ _____
Patient Name (please print) Relationship to patient

_____ _____
Witness Date

Rev. 2/11/22 NH

Camille Holiner, PsyD Office Policies

Appointments: _____ (initial)

- Our office hours are 8:00am to 12:00pm, and 1:00pm to 5:00pm Monday through Thursday; On Fridays our office hours are from 8:00am to 12:00pm. Patient appointments are scheduled by calling during regular office hours.

Financial Policy: _____ (initial)

- An estimated payment is due at time of service by cash, check, money order, Visa, MasterCard, Discover, or American Express. Depending on the level of service provided there may be an additional fee that is patient responsibility to pay within 30 days of receipt of your statement.
- Patients are responsible for their co-payments and/or deductibles at the time services are rendered for patients on Preferred Provider Plans (PPO's) or Health Maintenance Organizations (HMO's).
- Any balance on an account that is greater than 30 days old is considered past due. A statement will be mailed on a monthly basis and will reflect the current balance for all services rendered prior to the date on the statement. Payment is due upon receipt of statement.
- Payment plans are offered upon request.
- If admitted to the hospital you will receive a physician's bill that is separate from the hospital bill.

Insurance: _____ (initial)

- Your insurance policy is a contract between you and your insurance company. While our billing professionals will do all they can to help our patients in communicating and negotiating with their insurance plan or other persons, we must inform patients that have any questions regarding coverage, benefits, or payment for services provided, is their responsibility to resolve.
- ***In the event of denials, errors, or non-covered services, the patient is responsible for all services rendered.*** If payment from your insurance carrier is not received within forty-five (45) days, we will seek full payment from you. Balance of services that are delayed or denied by your insurance company due to Coordination of Benefits information will become your responsibility after thirty (30) days.
- The Holiner Psychiatric Group and its employees do not guarantee that payment will be authorized for medical services; therefore, this office is not responsible for any adverse payment decisions or misuse of information.
- Notification of any change in your insurance status (i.e. new company, deductible, co-pay amounts) must be provided to the office forty-eight (48) hours in advance of next visit, or payment in full will be required.

Red Flag Policy: _____ (initial)

- "The Holiner Psychiatric Group must collect and store our patients' private medical, financial, and personally identifying data. We must therefore be vigilant in protecting the patient information to which we have access including medical, financial, and any other personal information contained in The Holiner Psychiatric Group's medical, appointment, or billing records."
- You must present a valid state issued photo identification card **prior** to being seen at **each** appointment.
- If you would like us to bill your insurance carrier, you must present a valid insurance card **prior** to being seen at **each** appointment, or payment in full will be required.

Miscellaneous Charges: _____ (initial)

- For charts in paper format you will be charged $25.00 for the first 20 pages and .50 for each page thereafter. For records in electronic format, you will be charged $25.00 for 500 pages or less and $50.00 for more than 500 pages.) and may take up to 15 business days to obtain. Report preparation fees are based on the time involved.
- Any returned checks are subject to a $30 service fee. Any returned check must be resolved before any future appointments can be arranged.
- The Holiner Psychiatric Group contracts with RS Clark and Associates, collection agency, to collect delinquent accounts. Once an account is placed with RS Clark and Associates, the patient must deal directly with RS Clark and Associates, for payment of the account. In the event of account placement with RS Clark and Associates, the applicable collection fees will be added to that account. Currently, these additional fees are equal to 25% of the total balance owed.
- ***If you do not cancel your appointment 24 hours in advance, our policy is to charge the rate of ($100.00) and is payable prior to future visits. No shows will be charge the Full Session Fee billed for the service reserved.*** These will not be billed to your insurance company. Please help us to serve you better by keeping your scheduled appointments or canceling in advance.

Refill Requests / Messages: _____ (initial)

- Any phone messages left after 3:00pm Monday through Thursday will be returned the next business day. Any phone messages left after 10:00am on Friday will be returned the following Monday.
- In the event that you call our office and your clinician is out your call will be returned the next business day. If you feel that your call needs urgent attention, please contact our main phone number at: 972-566-4591.

Emergency Situations / After Office Hours: _____ (initial)

- For urgent matters after 5:00 PM Monday through Thursday and urgent matters after 12:00pm on Friday please call our main phone number for the physician on call. In an emergency, call 911 or go directly to the nearest emergency room.

Cellular devices, cameras, camcorders or any other recording/ photo taking devices are prohibited: _____ (initial)

- To reduce the potential risk of a Federal HIPAA Violation recording and/or photo taking devices are prohibited, including but not limited to: cellular devices, camcorders, recorders

Disclosure: _____ (initial)

- During the course of your physician/patient relationship with The Holiner Psychiatric Group you may be referred to PsychIQ. The address of the entity is 7777 Forest Lane Building C Sute A-94, PMB#157 Dallas, Tx. 75230. In connection with any referral to the entity, you are hereby advised that Joel Holiner has an investment interest in the entity and therefore will receive, directly or indirectly, remuneration as a result of such referral. Should The Holiner Psychiatric Group at any time refer you to the entity and you prefer to use a different health care provider, you will be advised of the alternative health care providers and your right to choose one of these alternative health care providers.
- Rooms are being monitored for patient safety purposes

I have read and understand the Office Policy, and I agree to accept responsibility as described above. I also understand the Office Policy may be amended or modified from time to time by the practice. I am expressing my understanding by initialing next to each item on this page as well as signing below. If you have any questions, please feel free to ask our staff for assistance. Thank you for choosing us for your care.

_____ _____

Patient Name (please print) Date

_____ _____

Signature of Patient/Parent/Guardian/Representative Relationship to patient

CAMILLE HOLINER, PSYD.
FEE DISCLOSURE ACKNOWLEDGEMENT

We will make available our fee schedule for procedures upon request. Most fees are for office and/or hospital procedures. However, fees will also be incurred when you request services in addition to your regular services.

The following is a brief, non-comprehensive listing of such services:

1. Medical records processed for transfer (PhotoStat)	25.00 and up
2. Returned checks (NSF)	30.00
3. Letters to employer, school, etc.	25.00 and up
4. Disability forms, letters, etc	25.00 and up
5. Missed scheduled appointment without 24 hour notification	100.00
6. No shows	200.00

- Our office will not fill out any paperwork, forms or write any letters in regards to CHL (concealed handgun license) clearance.

The above fees may not be recovered by your insurance plan and are payable at the time services are rendered.

_____ _____
Name of Patient (Print) Signature of Patient / Date

_____ _____
Patient Representative (Print) Signature of Representative / Date

_____ _____
Representative Relationship to Patient (Print) Witness / Date

NOTICE OF PRIVACY POLICIES AND PRACTICES

The Holiner Psychiatric Group
7777 Forest Lane Suite C833, Dallas, TX 75230
Office: 972-566-4591 Fax: 972-566-6679
Camille Holiner, PsyD.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

All items outlined in this policy apply to both paper and electronic formats of medical records and protected health information.

INTRODUCTION

The Holiner Psychiatric Group is committed to treating and using protected health information about you responsibly. We are permitted to use and disclose health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care you receive. This notice describes our privacy practices. We may change our policies and this notice at any time. You can request a paper copy of this notice, or any revised notice, at any time. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations. For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We are permitted to use and disclose your health information to those involved in your treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We are permitted to use and disclose your health information to bill and collect payment for the services we provided to you. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

We are permitted to use and disclose your health information for the purpose of health care operations, which are the activities that support this practice and ensure that quality care is delivered. For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

DISCLOSURES THAT CAN BE MADE WITHOUT YOUR AUTHORIZATION

These are situations in which we are permitted to use or disclose your health information without your written authorization or an opportunity to object.

Public Health: We may disclose your health information for public health activities mandated by federal, state or local government for the collection of information about disease, vital statistics or injury by a public health authority.

Abuse or Neglect: Because Texas law requires physicians to report child abuse or neglect, we may disclose health information to a public agency authorized to receive reports of child abuse or neglect.

Healthcare Oversight: We may disclose your health information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections.

Law Enforcement and Legal Proceedings: We may disclose your medical information if asked by a law enforcement official. We may also release information if we believe the disclosure is necessary to prevent or lessen imminent threat to the health or safety of a person. We may disclose your health information in the course of judicial or administrative proceedings in response to an order of the court or other appropriate legal process.

Worker's Compensation: We may disclose your health information as required by worker's compensation law.

Military and National Security: We may disclose your health information for specialized governmental functions.

Research and Medical Examiners: We may release health information to researchers for research purposes. We may release your health information to a coroner or medical examiner to identify a deceased person or a cause of death.

Business Associates: We may disclose your health information to "business associates" to perform our day-to-day operations. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider.

Appointment Reminders: We may contact you by telephone, mail or both to provide appointment reminders.

Required by Law: We may release your health information when the disclosure is required by law.

Other Uses or Disclosures: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

YOUR RIGHTS UNDER FEDERAL LAW

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information, WE DO NOT HAVE TO AGREE TO THIS RESTRICTION.
- The right to limit disclosure to family members, relatives or friends who may or may not be involved in your care. Restrictions must be submitted in writing to the person listed at the end of this document.
- The right to request that we send communications concerning health information by alternative means or to an alternative location. The request must be submitted in writing to the person at the end of this document and we are required to accommodate only reasonable requests.
- The right to inspect and copy your protected health information that is within the designated record set. Texas law requires that request for copies are made in writing and we require requests for inspection also be made in writing. Texas law requires us to provide copes or a narrative within 15 business days from receipt of your proper request. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based fee.
- The right to amend or submit corrections to your protected health information in the designated record set. If we refuse to allow amendment, we will inform you in writing.
- The right to receive an accounting of disclosures that are other than for treatment, payment, health care operations or made via an authorization signed by either you or your representative.
- The right to receive a printed copy of this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of The Holiner Psychiatric Group please contact:

Privacy Officer
The Holiner Psychiatric Group
7777 Forest Lane, Suite C-833
Dallas, Texas 75230
972-566-4591

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C., 20201

OUR RESPONSIBILITIES

The Holiner Psychiatric Group is required by law and regulation to protect the privacy of your health information, to provide you with this notice of our privacy practices with respect to protected health information and to abide by the terms of the notice of privacy practices in effect.

The Holiner Psychiatric Group
7777 Forest Lane Suite C833 Dallas, TX 75230
Office: 972-566-4591 Fax: 972-566-6679

REVIEW ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICIES AND PRACTICES

CAMILLE HOLINER, PsyD.

I have reviewed The Holiner Psychiatric Group's Notice of Privacy Practices, which explains how my health information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____	_____
Name of Patient or Personal Representative	Date
_____	_____
Signature of Patient or Personal Representative	Description Personal Representative's Authority
_____	_____
Witness	Date

AUTHORIZATION TO DISCLOSE VERBAL HEALTH INFORMATION

The Holiner Psychiatric Group
Camille Holiner, PsyD
7777 Forest Lane Suite C833, Dallas, TX 75230
Office: 972-566-4591 Fax: 972-566-6679

Patient Name (please print) _____ Date of Birth _____

Social Security Number _____ Phone # _____

I HEREBY AUTHORIZE DISCLOSURE OF INFORMATION TO/FROM THE NAMED INDIVIDUAL(S) OR ORGANIZATION(S) LISTED:

Full Name _____ **Relationship to Patient** _____ **Phone/Email** _____
☐Release all Health Information
☐Release all Billing (including payments, collections, ect.)
☐Release Other (Specify):_____

Full Name _____ **Relationship to Patient** _____ **Phone/Email** _____
☐Release all Health Information
☐Release all Billing (including payments, collections, ect.)
☐Release Other (Specify):_____

Full Name _____ **Relationship to Patient** _____ **Phone/Email** _____
☐Release all Health Information
☐Release all Billing (including payments, collections, ect.)
☐Release Other (Specify):_____

- **I understand that incomplete forms will be null and void; no exceptions.**
- **I understand that disclosure of my health information does not include mailing or faxing copies of my medical records; I must complete a medical records release in order to have copies of my medical records mailed or faxed to the named individual(s) or organization(s).**
- I understand that specific information to be disclosed may include history of *Drug or Alcohol Abuse* or *Mental Health Treatment*, information concerning communicable diseases such as *Human Immunodeficiency Virus (HIV)*, and *Immune Deficiency Syndrome (AIDS)*, laboratory test results, treatment progress, and any other such related information. **This authorization will expire 1 year from the date of my signature.**
- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I further authorize that a photocopy of this authorization is acceptable as an original.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.
- The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to: Privacy Officer: 7777 Forest Lane, Suite C-833 Dallas, TX 75230 **Phone:** 972-566-4591 **Fax:** 972-566-6679

Name of Patient or Personal Representative _____ Date _____

Signature of Patient or Personal Representative _____ Description of Personal Representative's Authority _____

Witness _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

The Holiner Psychiatric Group
Camille Holiner, PsyD
7777 Forest Lane Suite C833, Dallas, TX 75230
Office: 972-566-4591 Fax: 972-566-6679

Patient Name (please print) _____ Date of Birth _____

Social Security Number _____ Phone # _____

A copy of my initial psychiatric evaluation ***will be sent*** to my referring physician unless checked ☐ Do not send

PLEASE RELEASE COPIES OF MY MEDICAL RECORDS TO THE INDIVIDUAL OR ORGANIZATION NAMED BELOW:

(By checking one of the following, you will be charged a fee. For charts in paper format, you will be charged $25.00 for the first 20 pages and .50 for each page thereafter. For records in electronic format, you will be charged $25.00 for 500 pages or less and $50.00 for more than 500 pages.)

- ☐ Entire Record
- ☐ Psychiatric Evaluation **(No charge for evaluations sent to referring physicians and/or primary care physicians)**
- ☐ Other (Specify): _____
- ☐ Obtain medical records

FULL NAME (Family Member / Doctor / Hospital / Attorney, etc.) _____ Telephone Number _____ Email _____

Address _____ City _____ State _____ Zip _____

- **I understand that incomplete forms will be null and void; no exceptions.**
- I understand that specific information to be disclosed may include history of *Drug or Alcohol Abuse* or *Mental Health Treatment*, information concerning communicable diseases such as *Human Immunodeficiency Virus (HIV)*, and *Immune Deficiency Syndrome (AIDS)*, laboratory test results, treatment progress, and any other such related information. **This authorization will expire 1 year from the date of my signature.**
- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I further authorize that a photocopy of this authorization is acceptable as an original.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.
- The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to: Privacy Officer: 7777 Forest Lane, Suite C-833 Dallas, TX 75230 **Phone:** 972-566-4591 **Fax:** 972-566-6679

Name of Patient or Personal Representative _____ Date _____

Signature of Patient or Personal Representative _____ Description of Personal Representative's Authority _____

Witness _____ Date _____

Internal use ONLY:

Pages Copied_____ Date Request Completed_____ Completed By_____ Date Denial Sent_____

Charge $_____ Payment: □ Cash □ Check #_____ □ MC □ Visa □ Discover □ Am Ex

Camille Holiner, PsyD
7777 Forest Lane, Suite C833
Dallas, TX 75230
972-566-4591

Credit Card Recurring Payment Authorization Form

Schedule your payments to be automatically charged to your credit card. Just complete and sign this form to get started!

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your Visa, MasterCard, American Express or Discover card. You will be charged each visit for the total amount due for that period. A receipt will be mailed/emailed to you and the charge will appear on your credit card statement. You agree that no prior-notification will be provided if the total payment is under **100.00**.

Please complete the information below:

I _____ authorize Joel A. Holiner, MD PA to charge my credit card
(full name)

indicated below for each scheduled visit.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

Amount Authorized $_____

Frequency: ☐ Weekly ☐ Monthly on the_____ ☐ Per Visit

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form. My signature above authorizes charges for session fees for any late cancellations (less than 24 hour notice), session fees for any no-shows and outstanding balances for insurance claims not paid within 90 days.