Pamela Geraghty, LCSW, CHt
License # 64228
2774 Jefferson Street • Carlsbad • CA • 92008

Phone: (760) 575-4512 Fax: (760) 434-4789 Email: pamela@pgeraghtylcsw.com

CREDIT CARD AUTHORIZATION

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request.

I,____ , am authorizing Pamela Geraghty, LCSW, CHt to use my credit card information to charge my credit card in the event that:

______I do not notify her of my inability to attend a scheduled therapy appointment

______ I do not cancel my appointment at least 24 hours in advance

($75.00 late fee will apply)

______A check is returned for any reason **(additional $35.00 fee for returned checks)**

______There is an outstanding balance after 30 days from date of services rendered

______I am electing to use this card for co-pay fees for services rendered

Type of Card: VISA MASTERCARD DISCOVER

Card Number:____

Verification / Security Code: ____________________Exp. Date:________ /_____________

Billing Address of Card Holder (if different than patient):

____

____

Patient Name: ____

Cardholder Name (If different than Patient): _______________________________________

Cardholder Signature: ________________________________ Date: __________________