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CREDIT/DEBIT/HSA PAYMENT AGREEMENT

_____ _____
Patient Name Patient Date of Birth

I, _____(patient or parent/guardian if patient is a minor), authorize Aimee O'Keefe, LCSW to keep my signature on file and to charge my Visa, MasterCard, listed below for COPAYMENT, OUT OF POCKET COSTS (e.g., fees associated with checks returned for insufficient funds), and/or LATE CANCELLATION/NO SHOW amounts due on the account of the patient named above. The card(s) may be charged **automatically** after the original date and time of service if payment was not made at the time of service.

☐ Visa/ ☐ MasterCard

Card#: _____

Card Exp Date: _____(month) / _____(year) CV (3-digit code) _____ Billing Zip Code _____

☐ Visa/ ☐ MasterCard

Card#: _____

Card Exp Date: _____(month) / _____(year) CV (3-digit code) _____ Billing Zip Code _____

I understand this form is valid unless I cancel this authorization by written notice. If I choose to cancel this form, I assume full responsibility for paying the above-named patient's charges in full at the time of service or I will make alternative arrangements for payment. I further understand that withdrawal of this authorization or declination of my credit/debit card upon payment processing will affect my ability to schedule appointments and may result in cancellation of future appointments.

_____ _____
Name on Card Cardholder's Relationship to Patient

_____ _____
Billing Address City, State Zip

_____ _____
Signature of Cardholder Date