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Dr. Amy D. Miller & Associates, Ltd.

CREDIT CARD AUTHORIZATION AGREEMENT

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

If there is a balance remaining on your account that is not payable by insurance benefits, you are then responsible for this balance. In Addition, in case of late cancellations and/or no shows for scheduled sessions, or if a check is returned unpaid, you will be charged the full session fee. An additional $25 will be assessed for returned checks.

I, ________________________________, am authorizing Dr. Amy D. Miller, to use my credit card information to charge if I carry an account balance not covered by insurance or in the event that I do not notify her of my inability to attend scheduled therapy appointments and/or do not cancel my appointments at least 48 hours in advance, or if a check is returned for any reason, as agreed to in the signed Client Billing Policies/Late Charges form.

I will not dispute charges ("charge back") for sessions I have received or for appointment I have missed according to the above referenced policy.

Card Type (circle one): Visa, MasterCard, American Express

Card#: _____________________________ Expiration Date (Month/Year): _____/_______

Name as Printed on Card: ____

Verification/Security Code (code on back of card by signature line): ________

Billing Address: ____

City: _________________________ State: _____________ Zip Code: ___________

Email Address (To Send Receipts): ____

Phone #:__________________

Print Name: _________________________________

By signing below I am authorizing Dr. Amy D. Miller to charge for missed appointments and/or outstanding account balances.

Signature: _______________________________________ Date: _____/_____/_____

Caring - Supportive - Competent