

# Pre-Authorized Mental Health Care Payment Form

I, \_\_\_\_\_, authorize Tara Moser, LCSW of Delta Family Counseling, LLC to keep my signature on file and charge my credit card account for:

\*Charges for appointments attended (fees for services rendered)

\*Charges for missed appointments (including those canceled within 24 hrs)

\*Balances for charges not paid within 90 days

I understand that I may revoke this agreement at any time by a written request.

Client name: \_\_\_\_\_

Cardholder name: \_\_\_\_\_

Cardholder billing address: \_\_\_\_\_

- 
- Visa
  - MasterCard
  - Discover
  - American express

Account number: \_\_\_\_\_

Expiration date: \_\_\_\_\_

Signature: \_\_\_\_\_

Email address (optional): \_\_\_\_\_

Tara Moser, LCSW agrees to charge only for reasons stated above at the agreed upon rates as committed to in policy letter.