Andrea Rusher, LCSW, LLC
12798 Forest Hill Blvd
Suite 303
Wellington, Florida 33414

Credit Card Authorization Form

Please read thoroughly and complete the following information. Initial where indicated (___). This form will be stored securely in your clinical file and may be updated periodically. No information contained in this form will be stored electronically.

In case of late cancellations, missed scheduled appointments, bank returned checks and/or unpaid balances, your credit card will be charged. In addition, any therapy sessions or support conversations conducted via the phone/text will be charged on a prorated basis (___).

I, _____, am authorizing Andrea Rusher, LCSW, LLC to charge my credit card in the event that I fail to notify her of my inability to attend a scheduled therapy session, do not cancel a scheduled appointment 24 hours in advance, have a check returned from my bank, have an unpaid balance, or participate in a therapy session via the phone and/or supportive conversations over 10 minutes.

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

Card Number: _____ Expiration Date: _____

Name as printed on the card: _____

Verification/Security code (3 digit code on the back of card by signature line):____

Billing address of the card: _____

City: _____ State: _____ Zip: _____

By signing below I am authorizing Andrea Rusher, LCSW, LLC to charge my credit card according to the guidelines outlined above.

Signature: _____ Date: _____

Parent/Guarantor Signature (If applies):

_____