

Mary Englund, Psy.D., LLC
1805 North Mill Street, Suite B
Naperville, IL 60563

Authorization to Secure Payment

I, _____ authorize Mary Englund PsyD, LLC to process payment on my Visa, MasterCard, or Discover Card for any balance due that has not been paid **30 days after the balance is accrued.**

I understand that if the appointment is missed and I do not follow the cancellation policy as specified Mary Englund PsyD, LLC is authorized to charge my credit card the same as the missed appointment.

I understand that if my card is declined, Mary Englund PsyD, LLC may put my credit card payment through on another day when funds become available.

I understand that I have given Mary Englund PsyD, LLC my credit card information. I further understand that if I miss a scheduled appointment or fail to provide 24 hours notice, my credit card will be charged the full amount of the session.

I have read and understand this form. I attest that the information below is true and accurate.

Signature of Card Holder

My credit card information is as follows:

Cardholder's Name

Client's Name

Credit Card Account Number

Expiration Date

Is this a debit card?

Yes No

Today's Date

CVV.

Zip Code

Please indicate if you would like your session Co-pay automatically charged to your Credit card. Yes No Amount of Co-Pay _____

By providing the following e-mail address, I give Mary Englund, Psy.D., LLC authorization to communicate with me/ and or submit a bill to the e-mail address listed below. I also understand that by providing the following e-mail address, I accept the HIPAA risks associated with electronic submission of data.

E-mail Address: _____