Lorraine Storm, MS, LPC
Health Counseling PDX
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(503) 862-3434
lorraine@healthcounselingpdx.com

I, _____, (DOB ____/____/____) hereby authorize Lorraine Storm, MS, LPC to use the below credit card as payment for services. This card will be charged in the event that I have not provided 24-hour advance notice of cancellation prior to our appointment time. I further understand that the 24-hour advance cancellation policy will be strictly adhered to unless otherwise agreed upon by Lorraine Storm, MS, LPC, and I.

_____ (Initials) I agree to authorize the use of the below credit card information for regularly billed services.

_____ (Initials) I agree that I will be charged a fee ($75) in the event of failure to provide 24-hour notice.

Credit Card Information:

Cardholder Name (as it appears on the card): _____

Card Number: _____

Card Expiration Date: _____/_____

CSC verification code: _____

Billing Information that is attached to this card:

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Email: _____

I attest that I agree to this document and all the information provided is accurate to the best of my knowledge.
I further attest that I am allowed to all the rights and privileges that are associated with this card.

_____ _____/_____/_____
Cardholder/Representative SIGNATURE Today's Date

_____
Cardholder/Representative PRINT