ADHD FAMILY COUNSELING CENTER OF CENTRAL NEW JERSEY

Irv Finkelstein, LCSW

Licensed Clinical Social Worker

220 St. Paul Street
Westfield, NJ 07090

CREDIT CARD AUTHORIZATION FORM

CREDIT CARD TYPE ☐ **VISA** ☐ **MASTERCARD** ☐ **DISCOVER**

CREDIT CARD NUMBER ____________________

EXPIRATION DATE ____________________ **Card Code (on back)** ____________________

CARD HOLDER NAME ____________________

BILLING ADDRESS ____________________

CITY/STATE/ZIP ____________________

PHONE ____________________

AMOUNT **Only to pay for professional services**

I, ______________________________, authorize the use of the above listed credit card to pay the fees for **Irv Finkelstein, LCSW**. I understand that the credit card will be used at my request to pay for session fees**. I also give authorization to use the card to pay for any outstanding fees that are over 90 days overdue. I also authorize the card to be used to cover the cost for any fees occurred for missed sessions or sessions canceled with less than the 24 hours notice required. I understand that these transactions will occur without additional notice.** I understand that fee payment deadlines, and/or late fees are my responsibility. I further understand that I may be charged a penalty fee if the credit card company denies my credit card. I understand that a facsimile or photocopy of this form with my signature on it is the same as an original. A copy of the transaction will be mailed for your personal record. Please ensure that you complete this form in its entirety.

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Signature Date

Phone: 908 389-0682 *Fax: 908 389-0218*

Email: irv@adhd911.com