CHRIS KAEPPNER, PH.D.
Licensed Psychologist

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Authorization for Credit Card Charges And Cancellation/No-Show Policy

Cardholder Name: ____

Card Type (Circle one): VISA MASTERCARD DISCOVER AMER EXPRESS

Credit Card Number:____

Expiration Date: ________/___________ Authorization Code on Back: ________________

Name exactly as it appears on this card: ____

Billing Address for this card:
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I authorize charges to this credit card for professional services provided by Dr. Kaeppner. Charges will be run based on stored information, and will not require a signature for each individual transaction.

I understand and authorize use of this credit card for any account balance due for a period longer than 3 weeks, unless prior written arrangements have been made between Dr. Kaeppner and the client. I also understand that failure to cancel an appointment 48 hours in advance as per written office policy will result in a charge for that missed appointment, and I authorize use of the same credit card for such charges as well.

Please inform Dr. Kaeppner right away if your credit card information changes. This authorization will remain in effect until both treatment has ended AND all account balances have been paid.

____ ______________________
Signature Date