

Ellen V. Garbuny, LSW
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Butler, PA 16001
724-283-1593

Card Authorization

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

In case of late cancellations and/or no-shows for scheduled sessions, you will be charged the full session fee as stated in the Office Policies. All returned checks will be charged for the amount of the check plus \$25 for bank NSF fees.

I, _____, am authorizing the entity,
(print name)

Ellen V. Garbuny, LSW, the use of my credit card in the event that I do not notify Ms. Garbuny of my inability to attend a scheduled therapy appointment and/or do not cancel my appointment at least 24 hours in advance as agreed to in the Office Policies.

Furthermore, I also understand my card will be charged to settle any outstanding balances accrued with Ellen V. Garbuny, LSW

Card Type (circle one): Visa MasterCard Discover AmEx

Card #: _____ Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (3-digit code on back by signature line) _____

Billing Address: _____

(Street, City, State & Zip)

Signature _____ Date: _____