

## ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information. Session fees for all clinical treatment will be charged to the account designated on this form. This form will be securely stored in your clinical file and may be updated upon request at any time.

By signing this form I am authorizing Leanne Hart, LMFT to charge my credit / debit card for all **session fees including full payment, co-payments, no show / late cancellation fees, court time, non session related documentation (letters or reports), account balances and phone time over 10 minutes** as stated in Leanne Hart's Informed Consent form.

### **CLIENT INFORMATION:**

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Responsible Billing Party Name** (as shown on Credit Card/Account): \_\_\_\_\_

**Billing Address** (as registered with Credit Card Company/Bank):  
\_\_\_\_\_

**Mobile Number:** \_\_\_\_\_ **Email:** \_\_\_\_\_

### **ACCOUNT INFORMATION:**

**Venmo Username** \_\_\_\_\_

**OR**

**PayPal Username** \_\_\_\_\_

**OR**

### **Credit Card Information**

**Card Type** (Visa, MasterCard, or Discover): \_\_\_\_\_

**Card#:** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_

**Three Digit Card Code** (Located on Back of Card): \_\_\_\_\_

By signing this form I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date**

Please return this form to your provider

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**Leanne Hart, M.A., M.F.T.**  
**16152 Beach Blvd., Suite 269    Huntington Beach, CA 92647    (714)514-3779**

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