



LONG GROVE CENTER FOR  
*Emotional Health*  
EXCEPTIONAL CARE  
FOR ALL STAGES OF LIFE

## Payment Authorization Form

I authorize the Long Grove Center for Emotional Health to process payments on my credit card maintained on file for my missed or late cancel appointments, copays, co-insurance amounts, and outstanding balances.

I have been notified about the practice policies of the Long Grove Center for Emotional Health and understand that I will be charged the full session fee for a missed or late cancel appointment as my insurance company will not cover the cost of such an appointment. I also understand that any unpaid balance will be processed on my credit card.

*Please complete the following credit or debit card information.*

Name of Client: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Type of Card (Visa, Mastercard, Debit, etc.): \_\_\_\_\_

Card Number: \_\_\_\_\_

Exp. Date: \_\_\_\_\_/\_\_\_\_ Security Code: \_\_\_\_\_

Email \_\_\_\_\_

Authorizing Signature: \_\_\_\_\_ Date: \_\_\_\_\_