Credit Card Authorization

Lorene Noack, LCSW
LCS 20518
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530.575.0363
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lorenenoacklcsw@gmail.com

I,_____, am authorizing Lorene Noack, LCSW to use my credit card information to charge my credit card for our sessions or in the event that I do not notify her of my inability to attend a scheduled therapy appointment and/or do not cancel my appointment at least 24 hours in advance as agreed in the policies stated in the signed Office Policy/Informed Consent form.

Type of card (circle one) Visa Mastercard Discover American Express

Card Number_____Expiration Date_____

Name as Printed on Card_____

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

Billing Address

_____

Street City State Zip Code

_____

Signature Date