PRE-AUTHORIZED HEALTH CARE FORM

I authorize the practice of Heidi M. Behr, LCSW to keep my signature on file and charge my credit card account for:

- Charges for appointments attended
- Charges for missed appointments (those not cancelled within 48 hours)
- Balances of charges not paid by me within 90 days

I understand that I may revoke this agreement at any time by providing a request in writing.

Client Name _____

Card holder's Name _____

Card holder's Address _____

City _____ State _____ Zip _____

- Visa
- Master Card
- Discover
- American Express

Account Number _____

(card verification code_____)

Expiration Date _____

Signature _____

Heidi M. Behr, LCSW agrees to charge only for services rendered or for cancellation fee if appointment is not cancelled within 48 hours.