Eileen Moran, LCSW
1129 Northern Boulevard
Suite 404
Manhasset, NY 11030
Eileenlcsw@gmail.com
516-737-1241

Authorization for Credit Card Charges

For your convenience, you may authorize recurring charges to your credit card to pay for your therapy sessions. You will be charged the day of your therapy appointment unless other arrangements have been made. The charge will be made under the name **Eileen Moran, LCSW**. You agree that no prior notification is necessary to bill for no show or cancellations unless the amount billed each time exceeds **$180,** in which case you will receive notification in advance.

Name of Client_____

Account Type: ☐Visa ☐MasterCard ☐American Express,(AmEx) ☐Discover

Cardholder Name _____

Account Number _____

Expiration Date _____ Zip Code_____

CVV (3-digit number on back of Visa, MasterCard, or Discover; 4 digits on front of AmEx) _____

I authorize Eileen Moran, LCSW to charge this credit card for professional services and associated charges as agreed below. These charges may include:

Co-pay and/or co-insurance for session: $_____

Self-pay for session or payment for session not covered due to deductible: $_____

Other charges [specify]: _____ $_____

_____ $_____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify this practice in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date.

Signature of Authorized Credit Card User: _____Date:_____