PRE-AUTHORIZED HEALTH CARE FORM

I authorize ***Tracie Morrison Salmon, LPC, PA,*** to keep my signature on file and to charge my credit/debit card account for:

1. **Balances of charges not paid by me or insurance within 90 days.**
2. **Charges not paid during session.**
3. **All Services, past and present, rendered.**
4. **Cancellation fee if appointment is not cancelled within 24 hours by calling 214-535-5354.**
5. **Phone consultation in lieu of appointment.**
6. **A $5 credit card transaction fee each time it is used.**

Client's Name _____

Cardholder's Name _____

Cardholder's Address _____

City _____ State _____ Zip_____

[] VISA [] MasterCard

Account number_____
Expiration_____
CVV_____

Signature _____

Therapist agrees to only charge for services rendered or for cancellation fee if appointment is not cancelled within 24 hours.

_____ _____
Therapist's Signature Date