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. **Balance of charges not paid by me within 90 days.**
2. **Charges not paid during session.**
3. **All Services, past and present, rendered.**
4. **Cancellation fee (session fee) if appointment is not cancelled within 24 hours by calling or texting 214-535-5354.**
5. **Phone consultation/Tele-therapy in lieu of in-office appointment.**
6. **A $5 credit card transaction fee each time it is used.**
7. **I understand Tracie Morrison Salmon, LPC, PA does not accept insurance.**
8. **If I choose to use @traciemorrisonsalmon private business Venmo account, I will not hold her responsible if my side of the transaction is not put on private.**

Client Name/Cardholder's name_____

Cardholder's Address _____

City _____ State _____ Zip_____

Account number_____
Expiration_____
CVV_____
Phone number if you would like receipt texted: _____

Client 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