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 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 or texting 214-535-5354.**
5. **Phone consultation/tele-therapy in lieu of appointment.**
6. **A $5 credit card transaction fee each time it is used.**
7. **I agree to allow Tracie Morrison Salmon, LPC, PA to sign for all of my credit card transactions in lieu of myself, to cut down on COVID-19 transmission, for tele-therapy and late cancellation fees.**

Client's Name _____

Cardholder's Name _____

Cardholder's Address _____

City _____ State _____ Zip_____

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

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