

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 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.**
- 8. I understand Tracie Morrison Salmon, LPC, PA does not accept insurance.**

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