

ADHD FAMILY COUNSELING CENTER OF CENTRAL NEW JERSEY

Irv Finkelstein, LCSW
Licensed Clinical Social Worker

220 St. Paul Street
Westfield, NJ 07090

CREDIT CARD AUTHORIZATION FORM

CREDIT CARD TYPE VISA MASTERCARD DISCOVER

CREDIT CARD NUMBER _____

EXPIRATION DATE _____ Card Code (on back) _____

CARD HOLDER NAME _____

BILLING ADDRESS _____

CITY/STATE/ZIP _____

PHONE _____

AMOUNT Only to pay for professional services

I, _____, authorize the use of the above listed credit card to pay the fees for **Irv Finkelstein, LCSW**. I understand that the credit card will be used at my request to pay for session fees. **I also give authorization to use the card to pay for any outstanding fees that are over 90 days overdue. I also authorize the card to be used to cover the cost for any fees occurred for missed sessions or sessions canceled with less than the 24 hours notice required. I understand that these transactions will occur without additional notice.** I understand that fee payment deadlines, and/or late fees are my responsibility. I further understand that I may be charged a penalty fee if the credit card company denies my credit card. I understand that a facsimile or photocopy of this form with my signature on it is the same as an original. A copy of the transaction will be mailed for your personal record. Please ensure that you complete this form in its entirety.

Signature

Date

Phone: 908 389-0682

Fax: 908 389-0218

Email: irv@adhd911.com