



# SUMMIT COUNSELING

Sarah West-Effland LCSW, LLC, Owner of Summit Counseling  
306 SE MO 291 Highway, Lee's Summit, MO 64063  
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## Credit/Debit Card Authorization

I hereby authorize Summit Counseling to keep my signature on file and to charge my credit/debit card account for:

- All co-pays
- Missed appointment or late cancellation fees
- Deductible amounts per Explanation of Benefits (EOB)
- Co-Insurance amounts per EOB
- Records requests, letter writing, phone calls, consultations outside of session, etc.

Please provide your e-mail address to receive an electronic receipt for each credit card transaction

Please complete all fields. You may cancel this authorization at any time by contacting us.  
This authorization will remain in effect until cancelled.

| Client's Information                                    |            |      |          |      |
|---|------------|------|----------|------|
| Client Name:  |            |      |          |      |
| Client e-mail:  |            |      |          |      |
| Client Phone:   |            |      |          |      |
| Credit/Debit Card Information                           |            |      |          |      |
| Card Type:  | MasterCard | VISA | Discover | AMEX |
|   | Other      |      |          |      |
| Cardholder Name (as shown on card):                     |            |      |          |      |
| Card Number:  |            |      |          |      |
| Expiration Date (mm/yy):                                |            |      | CVV:     |      |
| Cardholder ZIP Code (from credit card billing address): |            |      |          |      |

I authorize Summit Counseling to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Client Signature:

Date:

For filling out this form electronically: Just type your name into the signature field(s) above to sign the form.