River Rock Psychotherapy & Consulting, Inc.
Laura Grimes, LCSW
4753 N. Broadway, Suite 608, Chicago, Illinois 60640
(v)773-659-9207 (f)773-275-3880
laura@riverrocktherapy.com www.riverrocktherapy.com

Payment Method Authorization

Date: _____

First Name | Middle Initial | Last Name

residing at _____

Street Address | Apartment or Unit Number | City | State | Zip

Date of Birth: _____ and telephone number: _____

Selections

Check box for selection

I hereby authorize River Rock Psychotherapy & Consulting, Inc., Laura Grimes, LCSW to place my credit/debit card on file in order to pay for any and all payments, copayments, coinsurance, deductibles, missed session fees, late cancellation fees, or outstanding balances on my account. I understand that I am financially responsible for all missed session fees when I do not contact River Rock Psychotherapy & Consulting, Inc., Laura Grimes, LCSW via email, letter, telephone, or voicemail by 24 hours in advance of the scheduled appointment. I understand that the card will be charged after River Rock Psychotherapy & Consulting, Inc., Laura Grimes, LCSW contacts me via email, letter, telephone, voicemail, or informs me in person that the charge will occur. I also understand that my credit card will not be used in any other way and that this credit card information will be stored in my confidential chart and properly secured in a locked cabinet. I further understand that I may rescind my authorization to use the card by submitting that request in writing to River Rock Psychotherapy & Consulting, Inc., Laura Grimes, LCSW at any time.

I understand that I may revoke this authorization at any time, but not retroactive to the release of information made in good faith by me, by writing to the above-specified parties. I understand that information released by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

Credit Card Information:

Name on Credit Card Account: _____
First Name | Middle Initial | Last Name

Type: _____ Number: _____

Expiration Date: _____ 3 Digit Code: _____

Card Billing Address If Different Than Above:

Street Address | Apartment or Unit Number | City | State | Zip

Signature of Person Authorizing **Date** **Signature of Witness** **Date**

Check box for selection

I have elected not to have a credit card on file with the understanding that I will pay for any and all payments, copayments, coinsurance, deductibles, missed session fees, late cancellation fees, or outstanding balances at the time of each visit. Payments may be made using cash, check, credit card, or healthcare reimbursement account card.

Signature of Person Authorizing **Date** **Signature of Witness** **Date**

This Authorization is valid until: _____
(must have date within the next 12 months)

Note: Authorization must have a selection filled out in its entirety in order to be valid.