Cheri L. McDonald, LMFT, Ph.D - A Place to Turn, Inc.
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PRE-AUTHORIZED HEALTH CARE FORM

I authorize the practice of Cheri L. McDonald, LMFT, PhD doing business as A Place to Turn, Inc. to keep my signature on file and to charge the credit card account for any or all of the following:

- Charges for appointments attended (this includes but is not limited to co-payments as determined by insurance plan, fees for services rendered, phone sessions)
- Charges for missed appointments (including appointments canceled without 24 hours notice as well as no-show appointments)
- Balances of charges not paid within 90 days

I understand that this Pre-Authorized Health Care Form is valid for 4 years and will be kept securely on file and used for the charges I incur as outlined above.
I agree to provide Cheri L. McDonald, LMFT, PhD and/or A Place to Turn, Inc with any changes and or updates in my billing information.
I understand that I may cancel the authorization at any time by providing a written request to Cheri L. McDonald, LMFT, PhD and/or A Place to Turn, Inc. at the above address.
This authorization is ***required*** before first session or alternative payment must be supplied before ***each*** session.

PLEASE PRINT

Patient's Name:_____

Card Holders Name:_____
Name as it appears on the card

Billing Address: _____
Card holder's billing address

City:_____State:_____Zip Code:_____

Credit Card Type: □ MasterCard □ Visa

Credit Card No :_____CVV (3 digit code_____

Expiration Date_____/_____/_____
mm dd yyyy

_____
Authorized Signature* (Must be an authorized user on the account) Date

*The authorized signature is a confirmation that this Pre-Authorized Health Care Form has been read and understood. The authorized signature authorizes Cheri L. McDonald. LMFT, Ph.D and/or A Place to Turn, Inc. to charge the above noted credit card account for charges incurred as outlined above. Prior notification of charges is not required.