NAPERVILLE
CLINICAL ASSOCIATES

PAYMENT AUTHORIZATION FORM

I authorize Jodette Kwasniak-Wheat, LCPC to process payments on my MASTERCARD or VISA or DISCOVER or AMERICAN EXPRESS credit card for my missed or late cancel appointments, copays, co-insurance amounts and outstanding balances.

I have been notified about the practice policies of Jodette Kwasniak-Wheat, LCPC and understand that I will be charged the full session fee for a missed or late cancel appointment, as my insurance company will not cover the cost of such an appointment. I also understand that any unpaid balance will be processed on my credit card.

My authorization in no way will compromise my ability to dispute a charge or question my insurance company's determination of payment.

Client Name _____

Billing Address _____

Name on Card _____

Card# _____ Security Code _____

Expiration Date _____

Check Your Preferred Card

☐ Mastercard ☐ Visa ☐ Discover ☐ American Express

_____ _____

Authorizing Signature Date