# Laila El-Asmar, LCSW-C, LLC

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## CREDIT CARD AUTHORIZATION FORM

Laila El-Asmar, LCSW-C, LLC accepts Visa, MasterCard and Discover only. Please complete the information below. Please **PRINT** all information. Thank You.

**Cardholder Information**

Card Type: ___VISA ___MASTERCARD ___DISCOVER ___DEBIT CARD (Visa or MasterCard)

Name as it appears on the credit card:_____

Card Number:_____ Expiration Date:_____

Card Identification Number (Last 3 digits located on the back of the credit card): _____


Billing Address:_____
(Where statement is mailed)

City:_____ State:_____Zip:_____

Phone:_____ Fax:_____ E-mail:_____

Receipt Required? ____YES ____NO If yes, please circle: Mail/ Fax/ Email

I understand that I am the responsible party and agree to pay for all charges incurred, including, but not limited to, insurance copays, deductibles, session fees, late cancellation fees, missed appointments and outstanding balances. I authorize Laila El-Asmar, LCSW-C, LLC to charge my credit/debit card for services rendered.

This form will be kept on file in the office of Laila El-Asmar, LCSW-C, LLC and will remain in effect until the expiration of the credit card account at which time a new authorization will be filled out. Patients may revoke this form by submitting a written request to the address at the top of this form. Please notify me immediately if the credit card on file is lost or stolen.

**Notice to Credit Cardholder:** By signing, Cardholder agrees that his/her signature on this form constitutes a "Signature on File" and is an agreement to pay all charges incurred as described above.

Cardholder Signature:_____Date:_____

Date Telephone/Letter Authorization Received:_____Date Copy Mailed to Cardholder:_____