Dina Varano, MA, LMHC
317.590.5351
fax 317.454.1353

CREDIT CARD AUTHORIZATION

If you would like to use a credit, debit, or flex benefit card for payment with your signature on file, please complete this section:

I, _____, hereby authorize Dina Varano, MA, LMHC to charge my credit card account for services rendered for the duration of my treatment or as requested in an amount not to exceed:

- ☐ $150 Initial consultation & assessment
- ☐ $110 50-minute counseling session
- ☐ $145 50-minute hypnosis session or 75-minute counseling session
- ☐ $165 90-minute counseling session

☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number: _____ / _____ / _____ / _____

Expiration Date: _____ /_____ Security Code (CCV): _____

For *VISA* or *Mastercard*, the credit card verification number is a 3-digit number printed on the back of your card. It appears after and to the right of your card number. For *American Express,* the verification number is a 4-digit number printed on the front of your card. It appears after and to the right of your card number.

Credit Card Billing Address

Name as it appears on card: _____

Street: _____

City:_____ State: _____

Zip Code: _____ - _____

Telephone: (_____) _____- _____

By signing below, I authorize the charges specified above and/or as indicated on my invoice from Dina Varano, MA, LMHC. The card issuer is authorized to pay the amount indicated on transaction receipts as "Total" upon proper presentation.

_____ _____/_____/_____
Cardholder's Signature Date

As the credit card holder, I authorize Dina Varano, MA, LMHC, to charge my credit card $90 per the therapeutic contract for missed appointments or late cancellations (canceling an appointment within 24 hours of the appointment time).

_____ _____/_____/_____
Cardholder's Signature Date

Your completion of this authorization form helps the office to protect you from credit card fraud. Dina Varano, MA, LMHC will keep all information entered on this form strictly confidential and in a secure, locked location.

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