Cynthia L. Sarris, LCSW, LLC | Dana M. Pelliccia, LPC | Andrea C. Basel, LCSW | Emily Samander, LMSW

Credit or Debit Card Payment Consent

Client Name ______________________________

Card Holder Name ______________________________

Card Type ______________________________

Card Number ______________________________

Expiration Date ______________________ **CCV** __________

Billing Zip Code ______________________________

I authorize the office of Cynthia L. Sarris, PA, LLC to keep the above card information on file and charge my credit/debit or health savings account card for professional services resulting in any co pays, coinsurance or deductibles due on my account. I further agree that a transaction fee of 3% will be added to this charge, if applicable.

If I do not cancel 24 hours in advance ofmy scheduled appointment time, I recognize that Cynthia L. Sarris, PC, LLC will charge my card $50 for any missed appointment fee, if applicable.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred.

Signature of Client ______________________ **Date** __________

Card Holder Signature ______________________ **Date** __________

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