Jim Cosenza, LCSW, CADC

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Payment Method Authorization

Date: ____________________

First Name Middle Initial Last Name

residing at ____________________

Street Address Apartment or Unit Number City State Zip

Date of Birth: ____________________ and telephone number: ____________________

Selections

☐ Check box for selection

I hereby authorize Jim Cosenza, LCSW to place my credit/debit card on file in order to pay for any and all payments, copayments, coinsurance, deductibles, missed session fees, late cancellation fees, or outstanding balances on my account. I understand that I am financially responsible for all missed session fees when I do not contact Jim Cosenza, LCSW via email, letter, telephone, or voicemail by 24 hours in advance of the scheduled appointment. I understand that the card will be charged after Jim Cosenza, LCSW contacts me via email, letter, telephone, voicemail, or informs me in person that the charge will occur. I also understand that my credit card will not be used in any other way and that this credit card information will be stored in my confidential chart and properly secured in a locked cabinet. I further understand that I may rescind my authorization to use the card by submitting that request in writing to Jim Cosenza, LCSW at any time.

I understand that I may revoke this authorization at any time, but not retroactive to the release of information made in good faith by me, by writing to the above-specified parties. I understand that information released by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

Credit Card Information:

Name on Credit Card Account: ____________________

First Name Middle Initial Last Name

Type: ____________________ Number: ____________________

Expiration Date: ____________________ 3 Digit Code: ____________

Card Billing Address If Different Than Above:

____

Street Address Apartment or Unit Number City State Zip

Signature of Person Authorizing Date **Jim Cosenza, LCSW, CADC Date**

☐ Check box for selection

I have elected not to have a credit card on file with the understanding that I will pay for any and all payments, copayments, coinsurance, deductibles, missed session fees, late cancellation fees, or outstanding balances at the time of each visit. Payments may be made using cash, check, credit card, or healthcare reimbursement account card.

Signature of Person Authorizing Date **Jim Cosenza, LCSW, CADC Date**

This Authorization is valid until: ____________________

(must have date within the next 12 months)

Note: Authorization must have a selection filled out in its entirety in order to be valid.