



# Eric Tivers, LCSW, MSSW

Licensed Clinical Social Worker • Certified School Social Worker

Lic# 149.01359

Mailing Address: P.O. Box 1661 • Round Lake, IL 60073 • Tel 224.636.3742 • Fax 847.886.7251

## Authorization for Credit Card Payment

I \_\_\_\_\_ authorize the payment of fees for \_\_\_\_\_ to  
(your name) (client's name)  
Eric Tivers, LCSW, MSSW for services rendered. Payment is due at time of service.

I authorize the following: (Please check all that apply)

- Payment of my balance in full.
- Payment of my balance whenever I forget a check or cash payment at time of therapy.
- Payment of fees for late cancellations or missed appointments.
- Payment of each balance that is 30 days past due.

\_\_\_\_\_ I understand that my credit card will be charged for late cancellations or no-  
(initial) shows as indicated in the Service Agreement Contract.

### Credit Card Information:

CC Type: \_\_\_\_\_ Account Number: \_\_\_\_\_

Exp Date \_\_\_\_\_ Name as it appears on Card: \_\_\_\_\_

Security Code on Back of Card: \_\_\_\_\_

Billing Address of this Credit Card including zip code:  
\_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Sign

\_\_\_\_\_  
Date