Lenny Gallo, LCSW, LCADC, ACT, CBIT
LennyGalloLCSW.com
3 Overhill Rd.
Verona, NJ 07044-2815
Phone: 973-559-3668
Email: Lenny@LennyGalloLCSW.com

Credit Card on File Agreement

++If PLEASE bring your Credit Card with you on the first visit.++

This document details how your credit card information is stored, and for what purposes it may be used.

Your credit card will be captured today and stored securely. I do not store your sensitive credit card information in my office. Your card is kept on file, offsite, in an encrypted payment gateway that is meant to enhance security because it reduces exposure at each visit. I offer this method of payment for your appointments and any balances on your account.

Your card will be charged for the following situations:

- As a primary method to pay for your appointments.
- Any balances due on your account.
- A$25.00 fee for any missed appointments.
- A $50.00 fee for returned checks.

You will receive a verbal conformation from me that your card is about to be charged and a receipt once your card has been charged. **It is my policy to not see anyone without having a valid credit card on file.**

By signing below, you are agreeing to the following:

I, _____, understand the importance of notifying my therapist at least 24 hours prior to my scheduled appointment that I am not able to keep my appointment. If I am experiencing an emergency, I will provide as much notice as possible to avoid being charged the Late Cancellation fee of $25.00. I understand that I will be charged a No-Show fee of $25.00 for failing to call and failing to show for my scheduled appointment. I give **Lenny Gallo, LCSW, LCADC, ACT** the authorization to charge my credit card $25.00 for each missed therapy session where 24 hours' notice is not given and $25 for each missed therapy session where I fail to call and show for the appointment. This credit card will also be used for all fees that have not been paid within 60 days (unless other arrangements for payment have been agreed upon in writing between me and my therapist). I will be provided a receipt for all charges made to this card. This card may also be used for payment of services upon my request (co-payment, deductibles, and fees). I understand that I may revoke this agreement at any time by providing a request in writing.

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Patient Name: _____

Account #:_____

Card Holder's Name (as shown on card):_____

□ Visa □ Master Card □Discover □ American Express

Expiration date (mm/yy): _____/_____

Cardholder Signature: _____

Date: _____