PRE-AUTHORIZED HEALTH CARE FORM

I authorize ***Tracie Morrison Salmon, LPC, PA,*** to keep my signature on file and to charge my credit/debit card account for:

1. **Balances of charges not paid by me or insurance within 90 days.**
2. **Charges not paid during session.**
3. **All Services, past and present, rendered.**
4. **Cancellation fee if appointment is not cancelled within 24 hours by calling or texting 214-535-5354.**
5. **Phone consultation/tele-therapy in lieu of appointment.**
6. **A $5 credit card transaction fee each time it is used.**
7. **I agree to allow Tracie Morrison Salmon, LPC, PA to sign for all of my credit card transactions in lieu of myself, to cut down on COVID-19 transmission, for tele-therapy and late cancellation fees.**

Client's Name ____

Cardholder's Name ____

Cardholder's Address ____

City _________________ State __________ Zip___________________________

Account number____
Expiration___________
CVV___________
Phone number if you would like receipt texted:_________________________

Signature ____

Therapist agrees to only charge for services rendered or for cancellation fee if appointment is not cancelled within 24 hours.

_______________________________________ _________________________
Therapist's Signature Date