Kathryn Miller Therapy
22 Parman Place
210-592-8307
wwwkathrynmillertherapy.com

Electronic Payment Authorization

There has been a policy change and all patients will need to give a 150.00 deposit . The purpose is to safeguard any missed appointment or late cancellation fees. This deposit will sit in your account and will be returned to you upon discontinuation of treatment.

In addition, we will be taking a credit card from you for any miscellaneous charges that are above and beyond the deposit. But, most people would like their deposit charged; the receipt will state that the amount charged is for deposit purposes
Please see the fee agreement form on the website under Insurance and Fees.

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request.
I give permission to have my card charged if I fail to make a payment or miss an appointment. You will be notified prior to any charge.

Client Name: _____

D.O.B: _____ Phone: _____

Email: _____

Responsible Billing Party (shown on Credit Card/Account):

_____

Card Type: ( ) Visa ( ) Mastercard

Card Number: _____

Three digit card code (on back of card): _____ Expiration Date: _____ Name (Printed)

_____ Signatu

_____ Date _____