Jodie Arceo, LCSW
P: (916) 794-6680
LCSW 87443
email: JodieArceoLCSW@gmail.com

Credit Card Authorization Form

I, _____ authorize Jodie Arceo, LCSW, to charge my provided card for out of pocket liabilities, co-payments, missed appointment fees and other incurred balances.

Co-Payment/Private Pay:_____ (or insurance stated out-of-pocket liability)

Missed Appointments: $55 (for missed appointments with less than 48 hour notice)

I understand that my card may be charged when:

- There is an applicable fee
- Insurance refusal to pay

I agree to not dispute charges or request "charge backs" for received services or missed/late cancellation of appointments.

Type of Card: Visa___ MasterCard___ Discover___

Card Number: _____-_____-_____-_____ Exp: _____/_____ CVC:_____

Card Holder's Name:_____ Billing Address:_____

Signature of Card Holder:_____ Client's Name:_____

Date:_____