Linda Berko RN, LCSW, BCD

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PRE-AUTHORIZED HEALTH CARE FORM

I authorize Linda Berko, LCSW, to keep my signatures on file and to charge my credit card account for:

Psychotherapy Fee per Session $ _____

Beginning on: (date) _____

* I understand I may revoke this agreement at anytime by providing a request in writing.

Patient's Name: _____

Card Holder's Name:_____ DOB: ___/___/___

Card Holder's Address:_____

City: _____ State: _____ Zip Code: _____

Visa Master Card Discover American Express

Account Number: _____ Expiration: ___/___/___

Signature: _____ Security Code: _____
(3 or 4 digit number on back)