Michael F. Shea, LICSW, LLC
2311 M Street, NW, Suite 304
Washington, DC 20037
202-966-0575

Credit Card on File Policy

Thank you for choosing Michael F. Shea, LICSW, LLC for your behavioral health needs. I am committed to providing you with exceptional care.

To streamline my billing and payment system and to provide a seamless, convenient way for patients to pay their bills, I request all patients keep an active credit card on file. Circumstances when your card will be charged include but are not limited to; at the conclusion of each session and for a missed or cancelled session/s as outlined in my "Cancellation Policy". I will email you a statement at the conclusion of each transaction and a calendar invite for the next session. The charges are processed by me, Michael F. Shea, LICSW, through a system known as "Square" and the credit card receipt will be emailed to you directly from them. Your credit card information is maintained with multi-layered security and no one other than myself has access to your information.

Credit Card Authorization

I allow, **Michael F. Shea, LICSW, LLC,** to automatically charge my credit card at the conclusion of each session and for a missed or cancelled appointment as described in the "Cancellation Policy".

If the credit card information give today changes, expires, or is denied for any reason, then I agree to immediately supply Michael F. Shea, LICSW, LLC with new, valid credit card information. I agree the new credit card information will be subject to the financial policy listed here and may be used with the same authorization as the original credit card which I presented in person. Michael F. Shea, LICSW, LLC reserves the right to charge an additional $25.00 declined card fee if he is unable to run a new credit card within 7 days. I understand that I am responsible for payment for all medical services provided to me by Michael F. Shea, LICSW, LLC at the time of service unless prior arrangements have been discussed. I understand that this form is valid until I cancel this authorization through written notice to Michael F. Shea, LICSW, LLC.

By signing below, I agree to the Credit Card Policy described above and I authorize Michael F. Shea, LICSW, LLC to keep my signature and a valid credit/debit card number securely on file in my account.

_____

Patient Name (please print clearly)

_____ _____

Signature of Patient/Credit Card Holder **Date**

_____

Print Name of Person Signing above and Relationship to Patient

Name on Credit/Debit Card: _____

Card Number: _____

Expiration Date: _____/_____ CCV# _____ Zip Code: _____