Sofia R. Friedberg, RN, LMHC, NCC, CCMHC
347.903.7068
sofia@sfriedberg.com
sfriedberg.com

CREDIT CARD AGREEMENT

I, _____, hereby authorize Sofia R. Friedberg, RN, LMHC to bill my credit card as listed below for professional services including the following:

- Regular session fees (at your request, as a convenience to you)
- Appointments that I have cancelled with less than 48 hours' notice
- Past due payment balances (fees more than 30 days overdue)
- Insufficient funds/returned checks and bank charges

Credit Card Type: MC ☐ Visa ☐ Amex ☐ Other ☐

Is this card linked to a Health Savings Account (HSA)? Yes ☐ No ☐

Name as shown on card: _____

Credit Card Number: _____

Expiration Date: _____

3-digit security code on the back of the card: _____

Billing zip code associated with the card: _____

There is a credit card processing fee of 2.95% + 30¢ per charge.

I request that you notify me as soon as possible if any of this information changes. This agreement will remain in effect until this agreement is cancelled in writing. *This information is kept strictly confidential.*

Patient's Name: _____
Patient's Signature: _____ Date: _____