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Authorization for Credit Card Charges And Cancellation/No-Show Policy

Cardholder Name (as appears on card): _____

Card Type (circle or select one): VISA / MASTERCARD / DISCOVER / HSA Card*

Primary Credit Card Number: _____

Expiration Date: ____/____/____ Authorization Code on Back: _____ Zip Code: _____

Secondary Card (*only necessary if your primary card is an HSA Card)

Cardholder Name (as appears on card): _____

Card Type (circle or select one): VISA / MASTERCARD / DISCOVER

Secondary Credit Card Number: _____

Expiration Date: ____/____/____ Authorization Code on Back: _____ Zip Code: _____

I authorize charges to this credit card for professional services provided by Dr. Kaepner. Charges will be run based on stored information, and will not require a signature for each individual transaction.

I understand and authorize use of this credit card for any account balance due for a period longer than 3 weeks, unless prior written arrangements have been made between Dr. Kaepner and the client. I also understand that failure to cancel an appointment 48 hours in advance as per written office policy will result in a charge for that missed appointment, and I authorize use of the same credit card for such charges as well.

Please inform Dr. Kaepner right away if your credit card information changes. This authorization will remain in effect until both treatment has ended AND all account balances have been paid.

Signature

Date