Relationship Resolutions, LLC
P: 412.921.3908, F: 412.927.0578
www.relationshipresolutions.org

969 Greentree Rd, Ste 108
Pgh, PA 15220

1100 Ashwood Cmns, Ste1101
Canonsburg, PA 15317

5433 Walnut Street, Ste 3
Pittsburgh, PA 15232

144 Emeryville Rd, Ste 120
Cranberry, PA 16066

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
Authorization will be required for most uses and disclosures of psychotherapy notes (where appropriate), marketing purposes or for any sale of PHI.

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members and discussion of your case at case consultation meetings. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as state licensing boards or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Megan Norris at Relationship Resolutions, LLC, 969 Greentree Road, Pittsburgh, PA 15220.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request. You have the right to restrict disclosures of PHI to your health insurer where the restrictions relate to services that were paid for, in full and in cash.
- **Right to be Notified.** You have the right to be notified in the event of a breach of you PHI, within

60 days of the discovery. A breach constitutes any acquisition, access, use and/or disclosure of PHI that is not permitted under the Privacy Rule.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. If we engage in fundraising, you have the right to opt out of such communications.
- **Right to a Copy of this Notice.** You have the right to a copy of this Notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Megan Norris, our Privacy Officer, at the address listed above, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint. The effective date of this Notice is September 23, 2013.**

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Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name: _____

Date of Birth: _____ / _____ / _____ Social Security Number: _____ - _____ - _____

I hereby acknowledge that I have reviewed and have been given an opportunity to receive a copy of Relationship Resolutions' Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer, Megan Norris at 412.921.3908.

_____
Signature of Patient/Client

_____
Signature of Parent, Guardian or Personal Representative*

Date: _____ / _____ / _____

_____
*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (i.e., power of attorney, health care surrogate, etc.).

□ Patient/Client Refuses to Acknowledge Receipt:

_____ Date: _____ / _____ / _____
Signature of Clinician

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Client Information

Client Name: _____ DOB: _____/_____/_____

Social Security Number: _____ - _____ - _____ Identified Gender ▢ Male ▢ Female ▢ Other

Marital Status: ▢ Single ▢ Married ▢ Widowed ▢ Divorced/Separated

Address: _____
Street Apt # City State Zip

Primary Phone Number: ▢ Home ▢ Mobile ▢ Work _____ - _____ - _____

Alternate Phone Number: ▢ Home ▢ Mobile ▢ Work _____ - _____ - _____

*Email Address: _____ Referral Source: _____
**This is required for credit card receipts and satisfaction surveys.*

Employer Name: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Relationship to client: _____

Insurance Information

Name of Insurance: _____

Member ID: _____ Group Number: _____

Phone Number: _____ - _____ - _____ (on back of card - usually says "For mental health / substance abuse…")

Are you the primary cardholder? ▢ Yes ▢ No

SS Number of Primary Cardholder (if different than your own): _____ – _____ – _____

DOB of Primary Cardholder (if different than your own): _____/_____/_____

Employer of Primary Cardholder (if different than your own): _____

Is this your primary or only insurance policy? ▢ Yes ▢ No

Name of secondary insurance, if applicable: _____

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CLIENT CONSENT FORM

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES: Relationship Resolutions offers a wide array of counseling services, including individual, family, couples, and group services. We are staffed by skilled and experienced licensed professional counselors, licensed marriage and family therapists, licensed clinical social workers, and licensed clinical psychologists. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy can be beneficial but there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. In the presence of these emotions, some clients start to wonder if the therapy is helping. Oftentimes, the level of distress is a necessary experience in the journey of self-discovery and change. The benefits of counseling can, therefore, far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, a reduction in maladaptive behavior, increased insight, and an increase in personal choice. While we cannot guarantee these benefits, it is our desire to work with you to attain your personal goals.

COUNSELING: We provide short and long-term counseling to address a variety of presenting and underlying problems which are a source of distress for our clients. Your first visit will be an assessment session in which your therapist will be gathering information to better understand your position. Your therapist will be attempting to clarify your goals for change and will offer their ideas about the way s/he can be assistance to you in achieving those goals.

The goal of Relationship Resolutions is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if transferring to a more suitable Therapist is right for you. If you and your Therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs. If you are not comfortable addressing your desire to switch clinicians with your therapist, please contact the client services representative at clientservices@relationshipresolutions.org or 412-921-3908 to discuss your situation.

All of the therapists at Relationship Resolutions are required to demonstrate cultural competence. We are aware that culture impacts a client's experiences, values, lifestyles, choices, and ways of interacting, and we strive to understand the role our client's culture plays in their life. If at any time you feel as though you are being discriminated against or treated disrespectfully based on your race, ethnicity, sexual orientation, or religious beliefs, please contact the client services representative to discuss your concerns.

At Relationship Resolutions, we believe that wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent or longer sessions are available if determined appropriate by your Therapist. If you must cancel or reschedule your appointment, we require that you call your therapist at least 24 hours in advance, whenever possible. This will free your appointment time for another client. Failure to do so will result in a $75 missed session fee.

FEE SCHEDULE:	*Diagnostic & Evaluation Session (1st visit)	$125-150
	*Regular Office Visits (50 minutes) (Individual/Family Therapy)	$100-125
	*Extended Office Visit (75 min.)	$125-150
	Phone Consults (Over 10 min.)	$50
	Written Reports (disability papers, letters, legal reports)	$40
	Returned check fee, per check	$25

**Fee varies by provider*

A reasonable fee will be charged for copies of any records requested by the Client.

All checks are to be made out to Relationship Resolutions and not your individual provider.

Any fees incurred by Relationship Resolutions from credit card companies, collection agencies or banks due to non-sufficient funds, payment disputes, or non-payment of fees will be passed along to the client.

Clients choosing to self pay for sessions may request changing to utilization of insurance benefits to cover treatment for future date appointments, but Relationship Resolutions will not submit insurance claims for past sessions which were previously paid out of pocket. Furthermore, no refunds will be given for prior session payments as a result of the Client switching from self-pay to insurance coverage.

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If your therapist at Relationship Resolutions is in network with your insurance company, we will file insurance claims for you, and we will honor any contractual agreements that have specific reimbursement restrictions and claim requirements. If your insurance company sends reimbursement checks directly to you, you are <u>legally</u> <u>obligated</u> to sign the checks over to the provider for services rendered. If you wish to file your own claim or if you are using out of network benefits, we expect full payment at the time of service, and we will provide you with a statement for services rendered. **Failure to provide payment of fees at the time of your session will result in a $5 non-payment at time of services fee**.

EMERGENCIES: Relationship Resolutions is not a 24-hour crisis service. In the event of a life-threatening emergency, you need to call 911 or immediately proceed to the closest emergency room. If you are experiencing a non-life threatening emergency, please call your therapist at the number s/he gives you at today's session.

CONFIDENTIALITY: Relationship Resolutions follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices offered to you.

Discussions between a Therapist and a Client are confidential. No information will be released without the Client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to suspicions or evidence of: child abuse, abuse of the elderly or disabled, abuse of patients in mental health facilities, sexual exploitation, and/or AIDS/HIV infection with possible transmission. Mental health professionals are not required to respond to Attorney subpoenas but are mandated to provide information requested via a court order for situations such as: criminal prosecutions, child custody cases, and/or suits in which the mental health of a party is in issue. Additionally, confidentiality is compromised in situations in which the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the Client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further.

By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result. You also understand that members of the Relationship Resolutions clinical team, the administrative staff, and any Interns have

access to your records, but are not ethically able to purposely obtain information about your work with another provider in the group. It is understood, however, that your therapist may utilize other Relationship Resolutions clinical contractors to consult on your case, as needed, given that the purpose of the consult is in the best interest of you, the Client.

CONSENT FOR EMAIL CORRESPONDENCE: Email correspondence poses the risk, not only of your email address being visible on the Internet, but also the content of your message, and the possibility of a computer virus. Also, we cannot assure that your family members, friends, co-workers etc. are not reading the email correspondence you receive. Relationship Resolutions email address use a secure site, and we maintain anti-virus software on our computers and make every effort to keep your information private.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

_____ _____

Name of Emergency Contact Telephone Number of Contact

CONSENT TO TREATMENT

By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

CONSENT TO PAYMENT

I hereby authorize payment of medical benefits to be made to Relationship Resolutions, LLC for services provided to me and the release of necessary medical information for insurance reimbursement purposes. **I understand that I am financially responsible for all charges whether or not paid by said insurance.**

If I need to cancel a session for any reason, the therapist requires 24 hours notice, prior to the session or I agree to pay the $75 late cancellation / no show fee. Additionally, if I do not provide payment at the time of the session, including any past due balances, I agree to pay a $5 non-payment at time of services fee. Moreover, any fees incurred by Relationship Resolutions from credit card companies, collection agencies or banks due to non-sufficient funds, payment disputes, or non-payment of fees will be my responsibility. Furthermore, I hereby authorize Relationship Resolutions, LLC to release any information necessary to secure such payment.

This assignment will remain in effect until revoked by me in writing.

_____ _____

Signature – Client/Parent Date

_____ _____

Signature – Spouse/Partner/Parent Date

_____ _____

Signature - Therapist Date

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CHILD INFORMATION FORM

Name_____ Date of 1st Appointment_____ Therapist _____

Date of Birth _____ Age _____ Gender: Male _____ Female _____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address:_____Physician's Phone:_____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer:_____

Date of last medical evaluation:_____ Date of next appointment:_____

Name of Psychiatrist (if applicable):_____

Current medications being taken:

1)_____Dosage/Freq_____ Start Date_____Purpose_____

2)_____Dosage/Freq_____ Start Date_____Purpose_____

3)_____Dosage/Freq_____ Start Date_____Purpose_____

4)_____Dosage/Freq_____ Start Date_____Purpose_____

Prescribed by: _____

Has your child ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital Mo/Yr Reason

Describe any important medical history, chronic ailments, or other health problems your child experiences:

Describe any other health problems or important medical history about your child's immediate family members and close relatives, including chronic ailments:

Does your child have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

DEVELOPMENTAL HISTORY

Any difficulties with the pregnancy?

Any difficulties with the delivery?

Most of the baby's developmental milestones seemed to be: ____On Time ___Early ____Late

At what age was toilet training completed? _____ Was toilet training a battle? ____Yes ____No

Are there any soiling or wetting difficulties now" ____Yes ____No *If yes, please explain:*

When the child started school, was there any difficulty in separating?_____

Does the child sleep alone?_____

SCHOOL HISTORY

Does your child experience any developmental, academic or behavior problems while in school or daycare, with peers or teachers?

(Circle One) YES NO If yes, please explain:_____

What was the last year of school your child completed?_____

What school is he/she attending? _____ Is your child home-schooled? (Circle One) YES NO

Please check all information which applies to your child's biological parents:

MOTHER		FATHER	
	____ living		____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____# of times		____ remarried ____# of times

With whom does your child live:_____

What custody and/or visitation orders are in place? :_____

*** Please copy orders to be placed in client's file.**

Does your child consider anyone else to be a "parent" in his/her life? YES NO If so, whom?_ _____

Describe your relationship with your child:

Currently:

In the past:

Describe your child's relationship with his/her other parent:

Currently:

In the past:

List first names and ages of your child's brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:

Describe any problems which occurred in your child's family relating to:

Alcohol/drug abuse:

Sexual/physical/emotional abuse:

Others living in the home with you:

Name	Age	Relationship	Grade/Occupation

MENTAL STATUS

Please check any of the following that describe how you believe your child has been feeling lately:

____sad ____anxious ____depressed ____frightened ____guilty ____angry

____worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ___helpless

Describe any behaviors your child has demonstrated that cause concern:_____

Has your child had any change in sleeping habits? (Circle One) YES NO Describe: _____

Has your child had any change in eating habits? (Circle One) YES NO

Describe:_____

Has your child ever considered suicide in connection with his/her **current** problem? (Circle One) YES NO

If so, please give a brief description with dates:_____

Has your child ever **considered suicide** in the **past**? (Circle One) YES NO

Has your child **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:_____

Has your child tried to hurt others or animals recently or in the past? (Circle One) YES NO

If yes, please explain:_____

LEVEL OF FUNCTIONING

Please describe what activities your child participates in:_____

Who is in your child's support network?

_____

Please describe your child's level of physical activity: _____

How much time does your child play on the computer, watch TV, or play video games: _____

Circle Behavior then check the category that applies Just a little Often Almost every day

1. Eats too much, overweight
2. Nightmares, awakens at night
3. Afraid of new situations, people
4. Stutters, hard to understand
5. Bedwetting; wets self in the a.m.

6. Holds back bowel movements
7. Has bowel movements in clothes
8. Does not act age
9. Cries easily
10. Wants help in things he should do alone
11. Clings to parents/adults
12. Keeps anger to self
13. Gets pushed around by other children
14. Bullies, fights constantly, is mean
15. Shy
16. has no friends
17. Feelings easily hurt
18. Feels cheated
19. Wants to run things
20. Can't keep still
21. Always into things
22. Fails to finish what they start
23. Stands there screaming/pouting
24. Throws and breaks things
25. Plays with on sex organs
26. Involved in sex play with others
27. Is not learning
28. Cannot seem to focus
29. Does not respect adults

HABITS (Check all that apply)

Thumbsucking _____ Unusual eating habits ____ Isolation ____ lying _____ Story Telling ____ Crying ____

Nail Biting ___ Head banging ___ Sleep difficulties ___ Rocking ___ Fantasies ___ Fire setting ___

Other:_____

Is there any other information regarding your child that you would like to share with your child's Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

_____

_____

Please list your therapy goals for your child:

_____

_____

_____

_____

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CONSENT FOR TREATMENT OF A MINOR

We/I, the undersigned _____, parent(s) and/or guardian(s) of a minor child _____, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.

Signed this ____day of _____, 20__

_____
Mother or Guardian

_____
Father or Guardian

The above explained to: (circle all that apply) Mother / Father / Guardian

By _____on the ____day of _____, 20__

_____
Witness

_____
Date

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Payment Agreement

In order to provide the best possible service to our clients, we adopt the following financial policies:

- Payment of session fees are due at the time of service. We accept cash, check, and most major credit cards. A $5 fee will be applied to any balance that is accumulated.
- Account balances must be paid prior to or at the beginning of the next session. Continuation of services may be dependent on having your account in good standing.
- Clients utilizing their insurance benefits to cover a portion or all of their fees are responsible for any balances which result from the insurance company denying payment. We make every effort to verify coverage and identify financial liability (such as deductibles, co-pays, etc.), however, it is ultimately the client's responsibility to know their coverage and resolve any non-payment issues directly with their insurance company..
- We refund any overpayment that might occur due to misquoted benefits or deductible completion.
- A $75 missed session fee will be assessed for any appointment not cancelled within 24 hours.
- Any fees incurred by Relationship Resolutions from credit card companies, collection agencies or banks due to non-sufficient funds, payment disputes, or non-payment of fees will be passed along to the client.
- To ensure compliance with these policies, we require a credit card be kept on file. Please complete the information below:

Visa / MC / Disc *(circle one)*

card #

Exp Date

CSV Code

By providing my signature below, I am authorizing Relationship Resolutions, LLC to keep a copy of my credit card on file for use to comply with the policies referenced above.

I understand that this form is valid through the expiration date on the card, unless I cancel the authorization through written notice to this organization.

Email that you wish receipt to be sent to: _____

Printed name: _____

Signature: _____

Date: _____