CREDIT CARD AUTHORIZATION

I require that you provide a credit card to have on file (see below for details).

Card type: _____ Visa _____ Mastercard _____Discover

Card Number: _____-_____-_____-_____

Expiration Date: _____/_____ Last 3 Digits on Back of Card: _____

Billing Address (including zip code):

_____

_____

_____

I hereby authorize Azita Afshar, Psy.D. to charge my credit card account for fees related to rendered services. These fees include but are not limited to copays/co-insurances, deductibles, services not covered by my insurance and/or self-pay fees. I understand that I will be able to provide payment through the method of my choice on current balances. However, outstanding balances that are past due 30 days will be charged to the credit card on file unless other arrangements have been made.

This authorization is valid until I provide Azita Afshar, Psy.D. with a written notice of cancellation.

Patient signature: _____ Date: _____