AZITA AFSHAR, PSY.D.

CREDIT CARD AUTHORIZATION

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

Card type: ______ Visa _____ Mastercard ______Discover ________Amex ______HSA

Card Number: __________-______________-____________-____________

Expiration Date: __________/__________ Last 3 Digits on Back of Card: _________

Billing Address (including zip code):

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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: ______________

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