Credit Card Authorization Form

THIS INFORMATION IS PRIVATE AND CONFIDENTIAL
AND WILL ONLY BE KEPT ON FILE BY
_____Madison Park Psychological Services_____

Patient name:_____ Date of Birth:_____

Cardholder name as it appears on credit card:_____

Phone number:_____

Billing address of credit card with zip code: _____

_____

Email address:_____

Card: ___Visa ___Master Card ___Discover ___American Express ___HSA/FSA

Credit Card Number:_____

Expiration Date: Month/Year _____

CCV OR CID Code: _____

All patients are required to have an active credit card on file. Payment is due at the time of service, or at the session following a "no show" defined as a cancellation with less than 48 hours notice. If you prefer to pay by cash or check, please do so at the time of service, or at the session following a "no show." If payment is not received at the time of service or at the next session following a "no show," we will wait fourteen (14) days for a check to be received by mail. After 14 days your credit card will be charged for any balance due.

I hereby authorize this credit card to be used for payments for services rendered by Madison Park Psychological Services. This authorization will remain in effect until the expiration date of the card or a written request to revoke the authorization is sent to us at:

Madison Park Psychological Services
51 East 25th Street, 5th Floor, Suite 4 New York, NY 10010

Please advise us immediately if your card is lost and/or stolen.

Card Holder Signature: _____ Date:_____