

Payment Authorization Form

I authorize Deanna K. Weiss, Psy.D. to process payments on my MASTERCARD or VISA or DISCOVER credit card for my missed or late cancel appointments, copays, co-insurance amounts and outstanding balances.

I have been notified about the practice policies of Dr. Weiss and understand that I will be charged the full session fee for a missed or late cancel appointment, as my insurance company will not cover the cost of such an appointment. I also understand that any unpaid balance will be processed on my credit card.

My authorization in no way will compromise my ability to dispute a charge or question my insurance company's determination of payment.

Credit/Debit Card Information

Client Name _____

Billing Address _____

Name on Card _____

Card # _____ Security Code _____

Expiration date _____ Circle Card Name: Mastercard Visa Discover

Authorizing Signature

Date