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VISA/MASTERCARD/DISCOVER AUTHORIZATION FORM

To improve the efficiency of patient payments, I require my patients to leave credit card information and charge authorization. Your credit card information will be held securely to the standards of federal guidelines that protect against identity theft.

When your insurance company has paid its portion of your bill, your portion (the co-insurance, co-payments or deductible) will be charged to your credit card. The billing period usually closes on the 21st of the month. Your credit card will be charged at that time for any outstanding balances. Your credit card will be charged for failed appointments or late cancellations on the date of the appointment. Please be reminded that I am not responsible for any debit card charges if you choose to register a debit card instead of a credit card.

I authorize Monica Schmitt, Psy.D. to charge any outstanding charges on my VISA, MASTERCARD or DISCOVER for my sessions including, co-payments, co-insurance amounts, failed appointment/late cancellation charges and outstanding balances.

I understand that if my card is declined, Monica Schmitt, Psy.D., may put my VISA, MASTERCARD or DISCOVER through on another day when funds become available. I also understand that this will in no way compromise my ability to dispute a charge or question my insurance company's determination of payment.

Card Type: _____VISA _____MASTERCARD ____DISCOVER

Doctor's Name: ______________________________

Patient Name: ______________________________ Date of Birth: ______________

Name of Card (please print): ______________________________

Card Number: ______________________________

Expiration Date: ______________________________ Security Code: ______________

Zip Code where billing statements are mailed ______________________________

Cardholder's Signature ______________________________ Date ______________