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_____
Client Name

Credit Card Authorization Form

To All Clients:

I appreciate and respect the trust you place in me to provide you with psychological care and services. In order for my practice to run smoothly and continue to offer you high quality care, I respectfully request that you sign below providing me, Dr. Bisignano, to keep your signature on file and charge your credit card for services. ***I will automatically charge your credit card the fee for appointments that are not cancelled 48 hours in advance.***

Thank you for your cooperation.

Date: _____

Name: _____
Please print clearly

Card type: *(please circle one)*

Visa MasterCard Debit American Express

Credit Card Number: _____

Expiration Date: _____

Security Code (3-digit code on back of card; Amex 4-digit on front of card): _____

Billing Zip Code: _____

Signature: _____
(Client)