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CREDIT CARD AUTHORIZATION

I, the undersigned, authorize Dr. Allison Kress to charge my credit card in the event that I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify my provider at least 24 business hours in advance for a cancelled appointment, as agreed to in the Treatment Consent. Furthermore, for outstanding payments of services rendered, I authorize charges to my credit card for the full amount due. I agree to not dispute charges for any of these reasons and understand that clinical information will need to be released if a dispute is initiated. I further authorize Dr. Allison Kress to disclose information about my attendance and/or cancellation to my credit card company if I dispute a charge. This form will be securely stored in a clinical file and may be updated upon request at any time.

Card Type: o Visa o MasterCard o Discover AMEX

Card #:
_____

Expiration Date: _____ Verification/Security Code: _____

Name (as printed on card):_____

Billing Address:
_____
(Street; City, State & Zip)

Signature: _____ **Date:** _____

(Patient or financially responsible party)
**Please note, your credit card will not be charged unless one of the following conditions apply:(a) no-show for a scheduled appointment, (b) cancellation less than 48 business hours in advance, or (c) participation in treatment (e.g., appointment or a phone/Skype session) without payment rendered.*

PLEASE SIGN BELOW IF YOU PREFER YOUR CREDIT CARD TO BE CHARGED FOR REGULARLY SCHEDULED APPOINTMENTS:

Signature: _____

*Date:*_____
(Patient or financially responsible party)