Alinda Small BPsycSc

Credit Card Authorization

I authorize the credit card on file to be used to cover full payment unless another method of payment was discussed and approved by Alinda Small BPsychSc. At least two business days are required for cancellation, or the full office visit fee will be charged.

_____ _____

Signature of patient or parent of minor **Date**

_____ _____

Alinda Small BPsycSc **Date**

Name as it appears on credit card:

_____

If cardholder is not patient, what is relationship to patient: _____

Visa_____**Mastercard**_____ ____**Amex**_____ _____

Credit Card Number: _____

Expiration Date_____ **Security Code**_____

Address where credit card bills are received including post code:

_____

Email address _____

Birthdate _____

Emergency Contact: _____

Phone Number: _____