Silber Psychological Services, P.A.
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AUTHORIZATION FOR CREDIT CARD CHARGES

Your credit card information will be kept confidential and secure and stored in an HIPAA compliant setting that is password protected for your safety. Once your information has been stored, this paper form will be shredded and destroyed. No credit card information will be kept in the office. While all secured methods to protect your information are in place no one can provide a 100% guarantee that any online system cannot be breached, thus you are accepting responsibility and risk in allowing Silber Psychological Services to store your information. By providing your credit card information you agree to the Business Policies of Silber Psychological Services and to notify this office if there are any changes to the credit card information provided. This credit card authorization will be used for office appointments, therapy sessions, professional services and for time scheduled on behalf of myself or my minor child that have not been paid directly by cash or check. This can include No-Show fees for appointments scheduled and missed, Late Cancellation fees (appointment cancellations that are less than 48-hour notice) and Professional services provided when you are not present such as phone calls, review of medical records, school observations, that are made on behalf of myself or the client(s) listed below. This authorization will expire on the last day of the month and year of your card's expiration, can be voided by either party at any time and will be voided if charges are consistently declined by your credit card provider.

FOR PARENTS WHO ARE SEPARATED OR DIVORCED: Additional documentation (separation agreements, court orders) will be required to be provided to Silber Psychological Services to substantiate your request to charge your card for an amount that is less than 100% of the fee. Split percentages or fixed payment amounts must equal to 100%. Each individual that is financially responsible for charges is required to either have a credit card authorization on file or have payment in the office on the day of the appointment or shortly after having been notified of a charge.

This credit card authorization is for ______________% percentage amount OR ____________ $ amount

Today's Date: ________________________________

Type of card: Master Card: _____ Visa: _____ American Express: _____ Discover: _____
Flexible Spending Account: _____ Health Savings Account: _____ Other: _____

Card Holder's Name ____

Credit Card Number ____________ ____________ ____________ ____________

Three Digit Security Number: ____________ Card Expiration Date: ______________

Card Holder's Phone Number ____

Card Holder's Signature ____

Mailing address of where the credit card statement is mailed:

____
Street City State Zip

IF this credit card authorization is for someone other than yourself then please complete the next section.
If NO other person then strike through and initial.

1. ____________________________________ ______________
Patient's full name Patient's Date of Birth

2. ____________________________________ ______________
Patient's full name Patient's Date of Birth

____________________________________ ______________
Witness Date