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CREDIT CARD AUTHORIZATION AGREEMENT
(Required)

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time. In case of late cancellations and/or no shows for scheduled sessions, or if a check is returned unpaid, you will be charged the full session fee. An additional $25 will be assessed for returned checks. In addition, you will also be charged for any unpaid balances which haven't been paid by yourself or by your insurance.

I,___________________________________, am authorizing Elizabeth Bias, Psy.D. to use my credit card information to charge my credit card in the event that I do not notify her of my inability to attend scheduled therapy appointments, and/or do not cancel my appointments at least 24 business hours in advance, or if there's any unpaid balance as indicated above, or if a check is returned for any reason. I will not dispute charges ("charge back") for sessions I have received or appointments I have missed according to the above policy.

Card Type (circle one): Visa, MasterCard, American Express

Card #_____________________________ Expiration Date:_______________

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Print Name:____

By signing below I am authorizing Elizabeth Bias, Psy.D. to charge my card for all reasons stated above.

Signature:____________________________________ Date:______________