SOUTH COUNTY
PSYCHOLOGICAL, INC.
Finding solutions and feeling better.

CREDIT CARD AUTHORIZATION

I, _____________________________________________, am authorizing South County
(print name)
Psychological, Inc. to charge my credit card listed below for:

(initial next to each option you wish to authorize)

_______ Payments of services when they occur.

_______ Advanced payments for services scheduled.

_______ Payments for appointments where I failed to show or failed to provide 24 hours advanced notice of my need to cancel the appointment.

My authorization to charge my credit card is for the full amount due. I will not dispute charges for sessions attended or where 24 hours advanced cancellation notice was not given.

I further authorize Susan J. Novak, PhD and South County Psychological, Inc. to disclose information about attendance and failure to attend/cancel to my credit card company as needed to address any dispute of charges I file with my credit card company.

This form will be securely stored in the client's clinical file. I may update this form at any time.

Card Type: (circle) Visa MasterCard American Express Discover

Card Number: ________________________________________ Expiration Date: __________

CCV Number (3 digits on back or 4 digits on front): __________

Name as Printed on Card: _______________________________________________________

Billing Address: ________________________________________________________________

Signature: __________________________________________ Date: ___________________
(credit card holder)

Name of Client, if different from credit card holder: ___________________________________

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