David J Kosins PhD
Licensed Psychologist

Visa / MasterCard Agreement

I authorize David J. Kosins, Ph.D. to keep my signature on file and to charge my Visa / MasterCard account for the balance of charges not paid by my insurance company within 90 days. Charges to credit cards are made between the 25th and the end of each month. I understand that charges will appear on my credit card statement as coming from "Associates in Behavioral Health Account Services (ABHAS)," which is Dr. Kosins' billing service.

Please check all that apply:

- ❒ The following specific dates or amount: _____
- ❒ All charges, including past balances and future services.

Patient name: _____

Cardholder name: _____

Cardholder address: _____

City: _____ State: _____ Zip: _____

Credit Card Account Number: _____ Exp. Date: _____ CSC #: _____

Cardholder signature: _____ Date: _____

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