David J Kosins PhD
Licensed Psychologist

Authorization for Credit Card Payment of Fees

Patient name: _____

Cardholder name: _____

Cardholder address: _____

Credit Card number: _____

Expiration date: _____ Security # on back of card: _____

I, _____ authorize payment of fees by my credit card
(your name here)

to David J. Kosins, Ph.D. for services rendered. I authorize my credit card to be used to resolve any and all balances in full on my account for psychological services, missed or forgotten payments, and/or appointments cancelled or no-shows within 24 hours as per the Agreement for Services statement. I understand that payment is required at the time of service and I may chose to use my credit card on file, credit swipe in the office, cash, check or debit card. I understand that I am required to provide up-to-date account information on file for regular appointment payments, forgotten payments and missed appointments. I also understand that late payments may be subject to an additional late payment fee. Ongoing noncompliance with payment terms may incur collections charges if I do not provide timely payment to resolve my balance.

Signature: _____ Date: _____

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