ANGELA E. MOSKOVIS, PH.D.
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(858) 259-6272

Credit Card Authorization Form

As a convenience to my patients, I accept MASTERCARD, and VISA. You may choose to keep a copy of your credit card on file, to be charged at the time of service in lieu of writing a check.

I, (Print Name)_____, authorize Dr. Moskovis, Ph.D. to charge my credit card for services rendered to myself, my family and/or my child. I understand that my (A) credit card information will be kept on file, (B) my credit card account will be charged at the time of service, and (C) by signing this document, I need not present my credit card at each visit for payment of services, I further understand that I may terminate this authorization with no less than 24 hours notice by sending Dr. Moskovis, at either address above, or a letter stating that I am terminating this authorization.

Per the practice guidelines given to me by Dr. Moskovis, Ph.D., I am aware that I will be charged for all appointments, including missed appointments, and those cancelled less than 24 hours in advance. I am also aware that other charges may include but are not limited to psychological testing, and report writing, school consultations, home visits, phone sessions, online therapy, and book, tape, CD, or DVD purchases.

Name on Credit Card:_____
Mailing Address for Card:_____
City:_____State:_____Zip:_____
Patients Phone:_____

Card Number:_____-_____-_____-_____
Expiration:_____3 Digit Code:_____

VISA____
MC ____

I HEREBY AUTHORIZE MY CREDIT CARD TO BE CHARGED FOR SERVICES AS STATED ABOVE, AND AS OUTLINED IN THE PRACTICE GUIDELINES GIVEN TO ME BY DR. MOSKOVIS, PHD

_____ _____
Cardholders Signature Date Signed

_____
Printed name of responsible party.