Diana Ali, PhD
PSY26034

Credit/Charge/Debit Card Preauthorization

This form will be securely stored in your clinical file.

I, _____, authorize Diana Ali, PhD to keep my signature and credit/debit/flex card information on file.

Diana Ali, PhD may charge the card listed below for the following services, unless other payment arrangements are made at the time of service:

1. Therapy session fees or partial fees;
2. Fees incurred for failure to cancel an appointment within 24 hours of the stated appointment time; and

Initials: _____

I understand that charges for services or materials will normally be posted to the card listed below within 72 hours of each session date if I choose to pay for that session by credit card.

Initial: _____

I understand that if Dr. Ali incurs a charge back fee based on my failure to provide correct information or update the card on file as needed, I am responsible to reimburse Dr. Ali for those fees.

Initial: _____

I understand that I may cancel this authorization at any time and that this authorization is valid until canceled in writing.

Initial: _____

If I am assuming session payment responsibility for the client whose name is listed above, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions.

Initial: _____

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Name (print): _____ Date: _____

Relationship to client: _____

Signature: _____

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CREDIT/CHARGE/DEBIT CARD INFORMATION

This form will be securely stored in your clinical file.

Cardholder Name (please print): _____

Relationship to client: _____

Billing Address (where statements are mailed): _____

City: _____ State: _____ Zip: _____

Card Type (circle one):

1. Visa 2. Mastercard 3. AMEX 4. Discover

Card Number: _____

Exp. Date: _____

CVV: _____

Cardholder Name (print): _____ Date: _____

Signature: _____