Valley Family Psychiatry, PLLC
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CREDIT CARD AUTHORIZATION

Please complete the following information:

I, _____ (*print name)*, am authorizing Valley Family Psychiatry, PLC to Charge my credit card in the event that I fail to show for a scheduled appointment as given to me by Dr. Patel or do not notify Dr. Patel of my inability to attend the scheduled appointment at least 24 business hours in advance, as agreed in our disclosure statement form that I filled out.

By signing, I agree to payment of my participating treatment either in person or by phone (if indicated). I have read, understood and agreed to the terms below:

SIGNATURE: _____

-There will be a charge for all appointments, including No Shows AND canceled appointments less than 24 hours in advance.
-I will not dispute charges for sessions that I have received or that I have canceled less than 24 hours in advance.
-I further authorize Dr. Patel to disclose information about my attendance/cancellation to my credit card company if I dispute the charge.

__ Please check here if authorizing Dr. Patel to use this CC for ongoing visits and treatment.

Card Type (circle one): _Visa _MasterCard _Discover _ American Express
Card #:_____
Expiration Date:_____
Name on Card:_____
Verification/Security Code:_____
Billing Address:_____
(Street, City, State & Zip)

Signature: _____
Date: _____
(client or financially responsible party)

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 24 business hours in advance, or participation in treatment (eg. appointment or phone session) without payment rendered.