Roula Creighton, MD, DFAPA

A diplomate of the American Board of Psychiatry and Neurology, Inc.

Credit Card Authorization

I hereby authorize Roula Creighton, MD to charge to this credit card the total amount due for outpatient psychiatric treatment at the time of service. I further authorize ongoing charges as they are due at each appointment time.

This authorization is to remain valid as long as said patient remains a patient of Dr. Creighton's practice, unless specifically revoked in writing.

Patient Name: _____ DOB: _____

Name on Credit Card: _____

Relationship to patient: _____ Contact Phone #: _____

Type: □ Visa □ M/C □ AM/EX □ Discover

Credit Card #: _____

Security Code: _____ Expiration Date: _____

Billing Address: _____

City : _____ Sate: _____ Zip: _____

Signature: _____ Date: _____