Dr. Harper Psychiatry & Psychotherapy

23440 Hawthorne Blvd. Suite 280

Torrance, CA, 90505

**Credit Card Processing Agreement**

Name (as it appears on your credit card)

Billing Address: street city state zip

Credit Card Type Credit Card Number

VISA/ MASTERCARD

Exp. Date

I hereby authorize Sarah Harper D.O. to use the above credit card, including circumstances where the credit card is not present. This credit card can be used to pay for services rendered and for any outstanding balances on this patient’s account including charges for missed appointments or late cancellations, and for fees associated with services provided outside of scheduled appointment times. This authorization is good through the credit card expiration date.

If charges are disputed and reported to your credit card company, I agree to allow Sarah Harper, D.O. to contact my credit card company and disclose the purposes of the disputed charges that may include information regarding attendance or cancellations of appointments.

Authorized Signature & Date