Stefanie A. Gray, Ph.D.
14802 Jones Maltsberger Rd., Suite 1201
San Antonio, TX 78247
(210) 570-2454

Authorization to Secure Credit Card/Debit Card Payment

I, ___________________________________ authorize Dr. Stefanie Gray to process payment on my Visa, MasterCard, Discover Card, or American Express for the purposes of:

1) My payment responsibilities as designated by our agreement.
2) Any outstanding balance that has not been received after 30 days of the service that was provided to me by Dr. Stefanie Gray (i.e. individual or group psychotherapy, telephone consultation, assessment, etc.).

_______I understand that I have given Stefanie A. Gray, Ph.D., PLLC my credit card information. I further understand that if I miss a scheduled appointment or fail to provide 24 hours notice, my credit card will be charged $150.

_______I understand that if my card is declined, Dr. Gray may put my credit card payment through on another day when funds become available.

I have read and understand this form. I attest that the information below is true and accurate.

____
Signature of Card Holder

____
Cardholder's name

____
Client's name

____ ____________ ____________
Credit Card Account Number Expiration date Security Code

____
Address on Credit Card Account

____
City, State and Zip Code

______________________ ____
Today's date Email address (for receipts)