Kristina Monroe, Psy.D.

Licensed Psychologist

CA: PSY24929 | NY: 019303

8235 Santa Monica Blvd., Ste. 303 • West Hollywood, CA 90046

323-546-7792 • drmonroe@kristinamonroe.com • www.kristinamonroe.com

Credit Card Authorization

Please make no marks nor add any comments to this page. It is your consent to make payment for services rendered, and your treatment is conditional upon your signing of this consent form without modification. This form will be securely stored in your clinical file and may be updated at any time upon request.

In the event that you miss or fail to cancel an appointment within 24 hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee.

An additional $25 fee will be assessed for: 1) returned checks, and/or 2) inaccurately disputed charge-backs.

I, _____, hereby authorize Kristina Monroe, Psy.D. to bill my credit card at the usual fee for professional services including all of the following:

- Appointments that I elect to pay for by credit card (including co-pays and co-insurance)
- **Missed appointments** or appointments that I have canceled with less than **24 hours** notice
- **Late arrival fee** (applicable for insurance clients)
- Record review, paperwork completion, telephone and email consultations
- Returned checks

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By signing below I am authorizing Kristina Monroe, Psy.D. to bill my credit card at the usual fee for professional services as described above. Additionally, I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I also agree to notify Dr. Monroe more than 24 hours in advance if I need to reschedule or cancel an appointment.

Signature: _____ Date: _____