Lori Rappaport, Ph.D.

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Credit Card Authorization Form

As a convenience to our patients, we accept MASTERCARD and VISA. You may choose to keep a copy of your credit card on file, to be charged at the time of service in lieu of writing a check.

I, (Print Name)_____authorize Dr. Lori Rappaport to charge my credit card for services rendered to myself, my family and/or my child. I understand that (a) my credit card information will be kept on file, (b) my credit card account will be charged at the time of service, and (c) by signing this document, I need not present my credit card at each visit. **I further understand that I may terminate this authorization upon no less than 24 hours notice by sending to Dr. Rappaport, at the address above, a letter stating that I elect to terminate this automatic authorization.**

Per the practice guidelines given to me by Dr. Rappaport, I am aware that I will be charged for *all* appointments, including missed appointments, and those canceled less than 24 hours in advance. I am also aware that other charges may include but are not limited to: psychological testing and report writing, school consultation, phone consultation/sessions, and book purchases.

Patient's name: _____ Soc. Sec. #: _____

Billing Address: _____

Home phone: _____

Credit Card: VISA MASTERCARD

_____Expiration:_____

I HEREBY AUTHORIZE MY CREDIT CARD TO BE CHARGED FOR SERVICES RENDERED AS STATED ABOVE, AND AS OUTLINED IN THE PRACTICE GUIDELINES GIVEN TO ME BY DR. LORI RAPPAPORT.

_____

Cardholder(s) Signature Date

_____

Printed name