CREDIT CARD AUTHORIZATION FORM

I, _____, the responsible party for Myself hereby authorize Judy Judge of Precision Billing to charge payments to the following credit/debit card for psychotherapy treatment with Victoria Ziskin, LMFT at 539 G St. Ste 104, Eureka, Ca. I understand any debit card that returns for non sufficient funds will be charged $30.00 NSF fee in addition to the clinical fee for services rendered. I understand I may choose any other qualified payment option (i.e. cash, check) at the time of service. I also can revoke this credit card authorization at any time. Authorization of use will be revoked upon discontinuation of therapy. Precision Billing is responsible for maintaining the privacy of my information

Credit Card Information:

_____ VISA _____ MASTERCARD

Cardholder Name (as written on card) _____

Credit Card Number: _____

Expiration Date: _____ / _____ (mm/yyyy)

CCV Number (three digit number located on back of card): _____

Email address for receipt _____

Please choose one of the following payment options:

$_____ payable at end of each therapy session with Victoria Ziskin, LMFT unless otherwise specified by myself verbally to Victoria Ziskin, LMFT or Precision Billing.

$_____ payable at end of session (date) _____ for the following date (s) of service _____

*****Please select **one** of the following options:*****

For missed appointments and late cancels you may charge this card **Initial** _____

OR

For missed appointments and late cancels, please send billing to my home address **Initial** _____

Receipts will be provided through email or mailing address if email address is not available.

Signature of Client/Parent/Legal Guardian: _____

Date: _____