Emily Cavell, PhD
CLINICAL PSYCHOLOGIST

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For your convenience, credit cards are accepted as a form of payment. If you would like to use this option, please complete the form below:

AUTHORIZATION FOR CREDIT/DEBIT CARD PAYMENT

Name: ____

Name (as it appears on card): ____

Type of Card: Visa MasterCard American Express

Account #: ______________________________

Expiration Date: ______________________________

Security Code #: ______________________________
(usually found on swipe strip on back of card: 3 or 4 digits)

Billing Address (*only needed if different than primary address*):

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AUTHORIZATION

Purpose: This form is used to register credit card information with Dr. Emily Cavell, allowing you to pay for services rendered. Your credit card information will be kept secured and confidential.

By submitting this form, the undersigned agrees to the following:

1. I hereby authorize Dr. Emily Cavell to make charges upon the credit card for any applicable fees for services I receive.
2. I understand that this form will be kept on file and will remain in effect until revoked in writing and/or the expiration date of the card has passed. I understand that it is my responsibility to complete a new credit card authorization form when the credit card has been renewed, revoked, cancelled or misplaced.
3. I understand that in the event any charge against this account is denied, I will be notified immediately to make payment in cash, money order, or certified check for any outstanding balance.
4. I understand that I can remove this authorization in writing at any time if I prefer to pay in cash, money order, or check.

Signature: ____ Date: ____________________