

## Credit Card Authorization Form

Payment such as copay, co-insurance and self-pay rates will be collected within 24 business hours of the service for both virtual and in person. No shows or last-minute cancellations will be a fee of \$100.

I, \_\_\_\_\_, hereby authorize Weston Psychological Associates, to charge my credit card services rendered:

Visa       Master Card       American Express       Discover

**Credit Card Number:** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_

**Credit Card Billing Address:**

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date