**Credit Card Authorization Form**

By your signature of this form, you authorize charges such as copay, co-insurance, and self-pay rates, to your credit card through Weston Psychological Associates for services rendered within 24 hours of the date of service for both virtual and in-person appointments.

[CANCELLATION POLICY: I also agree that my credit card can be charged for any session that is not canceled at least 24 hours prior to the scheduled session. No-Shows or Last-Minute Cancellations will be a fee of $100.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Weston Psychological Associates in writing of any changes in my account information or termination of this authorization.

**Credit Card Information:**

***Type of Card:***

# ( ) Visa ( ) Master Card ( ) American Express ( ) Discover

Credit Card Number:

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

***Credit Card Billing Address*:**

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

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP:

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_