Peter M. Levine, M.D., LLC

CREDIT CARD AUTHORIZATION FORM

It is a policy of this practice to keep a credit card on file in case of a "no show" visit (late or no cancellation). Your credit card information will be protected along with the rest of your information. You may also choose to have this credit card charged with your regular session fees.

Patient's Name: _____

Cardholder's Name: _____

Credit Card Billing Address: _____
City, State and Zip Code: _____

Credit Card Type: Visa Mastercard American Express Discover

Credit Card Number: _____

Expiration Date: _____/_____ CCVS/CVC2/CID: _____

I have read and agree to the office's policy of keeping my credit card information on file . This information may be used for payments of past due balances and/or no show visits. Regular fees will be charged with my verbal permission. I understand that this authorization will remain in force until Dr. Levine has received written notification from me of its termination in such time and in such manner as to afford Dr. Levine a reasonable opportunity to act on it.

Authorized Signature: _____ Date: _____