

**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: \_\_\_\_\_

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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: \_\_\_\_\_