Credit Card Authorization Form

I, _____, hereby authorize Dr. Michael S. Lax, PSY.D to use the following credit/debit card to pay for any service or charge incurred.

If there is an outstanding balance with the practice, I give him permission to use the card to pay the balance in full. This applies to any balance not paid in full at the time of the session, unless other arrangements have been agreed to. This authorization is good until the balance is paid in full, and the cardholder has rescinded the authorization or services are terminated with the practitioner.

I understand that there is a 24-hour cancellation policy once I have accepted an appointment time, and I will be charged $80 as a missed appointment fee if an appointment is not canceled 24-hours before my appointment time. Please note that insurance does not cover missed appointments.

Name on the Card: _____

Type of Card: Visa ☐ MC ☐ AmEx ☐ Discover ☐

Other ☐ _____

Credit Card Number _____

Expiration Date _____

Security Code _____

Billing Address _____

City, State, Zip _____

Phone Number _____

Signature of card holder: _____

Date: _____