Smitha Bhat, PsyD, PLLC

Credit Card Authorization Form

Client Name: _____

Cardholder Name (if different than client): _____

Cardholder Billing Address:

Street: _____

City: _____ State: _____ Zip: _____

Type of Card:

☐ HSA ☐ Visa ☐ American Express ☐ MasterCard ☐ Discover

Card Number: _____

Expiration Date: _____ CVV code: _____

I authorize Smitha Bhat, PsyD, PLLC to charge my card for professional services and fees including:

- Account balance at least 60 days overdue including fees not paid by my insurance company or other third-party provider (co-pay, deductible, co-insurance, denial of reimbursement or request for return of reimbursement after payment, etc.)
- Late Cancellation or Missed Session fees ($50 per occurrence)

Cardholder Signature: _____ **Date**: _____

Client Signature: _____ **Date**: _____