ROSE CITY
GEROPSYCHOLOGY, LLC

CREDIT/DEBIT CARD AUTHORIZATION AGREEMENT
EFFECTIVE DATE: 11/19/2018

Please complete the following information. Your credit/debit card information will be securely stored in your electronic clinical file and may be updated upon request at any time.

I understand that Rose City Geropsychology, LLC will charge my credit/debit card under the following circumstances…

- For professional services not covered by my insurance (e.g., deductibles, co-pays, co-insurance, consultation appointments, psychotherapy with a graduate student)
- In the event that I do not notify my therapist of my inability to attend a scheduled appointment at least 24 hours in advance, I will be charged a late cancellation fee as outlined in my informed consent
- In the event that I miss an appointment ("no show"), I will be charged a no-show fee as outlined in my informed consent

Card Type (circle one): VISA MasterCard Discover American Express

Card #: _____

Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (3 digit code on back of card by signature line): _____

Billing Address: _____

City: _____ State: _____ Zip: _____

I authorize Rose City Geropsychology, LLC to use my information to charge my credit/debit card according to the above policy. I agree to notify Rose City Geropsychology, LLC if my credit/debit card information expires or changes.

Signature: _____ Date: _____

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