Joy Piccolino, PsyD
Licensed Psychologist

Credit Card Authorization

Client Name: _____

I have implemented a policy which enables you to maintain your credit card information securely on file with Joy Piccolino, Psy.D., LP. In providing me with your credit card information, you are giving Joy Piccolino, Psy.D., LP permission to automatically charge your credit card on file for your outstanding balances on your account, including co-pays, deductibles, co-insurance, and late cancellations or missed appointments, unless other arrangements have been made.

Co-pays/Co-insurance: Co-pays and co-insurance are generally due at the time of session and may be paid using cash, check, or credit card. They are not automatically charged to the card on file at the time of service, unless requested.

Outstanding Balance: If your insurance provider has paid their portion of your bill and there is still an outstanding balance owed, Joy Piccolino, Psy.D., LP will notify you in session and/or via mailed billing statement. **If the balance is not paid in full within 15 days of the notice, at that time any balance owed will be charged to your credit card.** A copy of the charge will be e-mailed to you.

This agreement will expire on termination of services and settlement of final balance. The card holder may also revoke this consent at any time in writing while understanding that continued services may not be available if there is an unpaid balance.

Type of Card: ____ Visa ____ MasterCard

Credit card #: _____

Security Code: _____ Expiration Date:_____

Name on Card (if different): _____

Billing Address for Credit Card Statements (if different):

_____
Street Address *Zip Code*

Signature: _____ Date:_____