REBECCA KING, Psy.D.

4 Chatsworth Avenue

Larchmont, New York 10538

Telephone 917.848.8436

**DEBIT/CREDIT CARD PRE-AUTHORIZATION FORM**

I am planning to pay by cash or check at the time of visit. However, my credit or debit card will be kept confidentially and securely on file to be used only in the event that I delay payment by 14 or more days from the statement date. In the event that my insurance company reimburses Dr. Rebecca King directly, I will only be charged the difference between the fee agreed upon by Dr. Rebecca King and myself and the amount reimbursed by my insurer.

I authorize Dr. Rebecca King to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Discover ☐ MasterCard ☐ Visa

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder’s Name \_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Debit/Credit Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3 or 4 Digit Security Code \_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date\_\_\_\_\_\_ /\_\_\_\_\_\_

Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_

This authorization relates to all charges outlined in the in the Professional Fees section of the Client-Provider Agreement, including but not limited to charges for sessions I have attended or cancelled within 24 hours prior to a scheduled session or any other treatment related charges such as phone consultations, attendance at meetings or report writing.

I authorize Dr. Rebecca King to charge the debit or credit card listed above in accordance with the terms outlined in the Payment sections of the Client-Provider Agreement.

This authorization will remain effect until I cancel this authorization. To cancel I must give a 60 day notification to Dr. Rebecca King in writing and the account must be in good standing.

I promise not to dispute these charges (“charge back”). I further authorize Dr. Rebecca King to disclose information about attendance/cancellation/related services to my credit card issuer if I dispute the charges.

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Cardholder’s Signature Date