JANUARY MASSIN, PH.D.

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PAYMENT METHOD

Please indicate your preferred method of payment:

[ ] I prefer to pay by check for my sessions.

[ ] I prefer my credit card be billed for sessions.

This office requires that each patient keeps a credit card authorization on file in the event that you cannot pay or do not pay for fees that are outstanding or as pertains to any no-show visits. In this event, the office reserves the right to authorize your credit card. Your signature below indicates your agreement and consent to charge your credit card for any outstanding fees.

I, _____, (print name as appears on credit card), authorize January Massin, Ph.D. to submit any charges for services that are rendered to my credit card.

Type of Credit/Debit Card: __ Visa __ MasterCard __American Express

__Other (Please indicate type)

Card Number: _____

Expiration Date: _____

Security Code (usually 3 digits on back of card, American Express may be front of card)

Name as appears on Credit Card: _____

Relationship to Patient: _____

Billing Address: _____

_____

_____

Signature of Cardholder: _____

Date: _____