# OCEANSIDE PSYCHOLOGY CLINIC

## Credit Card Authorization

I, _____, hereby authorize Oceanside Psychology Clinic to use the following credit/debit card to pay for any service or charge incurred. If there is an outstanding balance with the practice, I give her permission to use the card to pay the balance in full. This authorization is good until the balance is paid in full, and the cardholder has rescinded the authorization or services are terminated with the practitioner.

I understand that there is a 24-hour cancellation policy once I have accepted an appointment time, and I will be charged if an appointment is not canceled 24-hours from my appointment time.

### Visa, Mastercard, American Express or Discover.

Credit Card Number: _____

Expiration: _____

Security Code: _____

Address associated with card (including zip code):

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Printed Name on card: _____

Signature of card holder: _____ Date: _____

*Please bring the completed form with your signature to your first session.*

Email: info@drnatha.com • (424) 666-0613