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AUTHORIZATION FOR AUTOMATIC BILLING

Name of Patient: _____Birth date: _____

This document authorizes Christina Remek, Psy.D. to automatically bill the credit card (below) for charges associated with my treatment or the treatment of the patient named above. Charges will be made to the credit card on or after the dates of service, and will include only those services contracted. Additional services will be billed only as mutually agreed to.

Card Type: ☐Visa ☐MasterCard ☐Amex

Card Number: _____ Exp. Date: _____

Name on Card: _____

Sec:_____

I understand that billed services will be subject to the parameters described in the "***Clinical Services - Policies and Procedures***" document, and I have received a copy of and understand these policies.

Address for Credit Card: _____

_____

Signature of Cardholder: _____

Date: _____