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Credit Card Authorization

Please make no marks or add comments to this page of the document. It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modification. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case (non-emergencies) where you miss or fail to cancel an appointment within 24 business hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee.

An additional $30 fee will be assessed for 1) returned checks, and 2) inaccurately disputed charge-backs.

I, _____, hereby authorize
Dr. David Shanley to bill my credit card at the usual fee for professional services including all of the following:

- Appointments that I elect to pay for by credit card
- Missed appointments
- Telephone consultations lasting longer than fifteen minutes
- Appointments that I have cancelled (non-emergencies) with less than 24 business hours notice
- Returned checks
- Fees not covered by insurance or insurance payments made to patient rather than provider

Credit Card/Debit Card Type (check one):

☐ Visa ☐MasterCard ☐American Express

Card #_____ Expiration Date: _____
Verification/Security Code (3-digit code on back of card by signature line): _____
Name as Printed on Card: _____
Billing Address: _____
City: _____ State: _____ ZIP: _____

By signing below I am authorizing Dr. David Shanley to bill my credit card at the usual fee for professional services as described above.

Print Name: _____

Signature: _____ Date: _____

☐ I would like receipts for each charge emailed to this address: _____