Sonia Juneja, M.D.
Washington Family Psychiatry, LLC

CREDIT CARD AUTHORIZATION FORM

It is a policy of this practice to keep a credit card on file in case of a "no show" visit (late or no cancellation). Your credit card information will be protected along with the rest of your information. You may also choose to have this credit card charged with your regular session fees.

Patient's Name _____

Cardholder's Name _____

Billing Address _____

_____

Credit Card Type Visa Mastercard American Express Discover

Credit Card Number _____

Expiration Date _____ CCVS/CVC2/CID _____

I have read and agree with the office's policy of keeping my credit card information on file. This information may be used for payments of past due balances and/or no show visits. Regular fees will be charged with my verbal permission. I understand that this authorization will remain in force until Dr. Juneja has received written notification from me of its termination in such time and in such manner as to afford Dr. Juneja a reasonable opportunity to act on it.

Authorized Signature _____ Date _____