THIS INFORMATION IS PRIVATE AND CONFIDENTIAL
AND WILL BE KEPT ON FILE ONLY BY GABRIELA PORTAS, LCAT

CREDIT CARD AUTHORIZATION FORM

CARDHOLDER INFORMATION		
PATIENT NAME:		
CARDHOLDER NAME (IF DIFFERENT THAN PATIENT):		
ADDRESS:		
CITY:	STATE:	ZIP
TELEPHONE:	ALTERNATE PHONE:	
BILLING ADDRESS (IF DIFFERENT FROM ABOVE):		
CITY:	STATE:	ZIP:

PAYMENT AUTHORIZATION
CARD TYPE: □ VISA □ MASTERCARD □ DISCOVER □ AMERICAN EXPRESS
CARD NUMBER: _____
EXPIRATION DATE: _____ /_____
CARD IDENTIFICATION NUMBER: _____ (3 DIGITS ON THE BACK OF YOUR CARD NEAR SIGNATURE PANEL OR 4 DIGITS ON FRONT FOR AMERICAN EXPRESS)
PRINTED NAME: _____

While you can pay by check or cash, Gabriela Portas, LCAT requires all clients to have an active credit card on file. Payment is due at the time of service, or at the session following a "no show," defined as a cancellation with less than 48 hours notice. If you prefer to pay by cash or check, please do so at the time of service, or at the session following a "no show." If payment is not received at the time of service or at the next session following a "no show," *your credit card will be charges for the balance due*.

I/we hereby authorize the above credit card to be used for payments for services rendered by Gabriela Portas, LCAT to (client) _____. This authorization will remain in effect until the expiration date of the card or a written request to revoke the authorization is sent to me at: Gabriela Portas, LCAT; 277 Richmond Parkway; Kingston, NY 12401.

Please advise us immediately if your card is lost and/or stolen.

Card Holder Signature: _____ Date:_____

Patient Signature (if not cardholder):_____ Date:_____

PREFERRED PAYMENT METHOD: □CREDIT CARD ON FILE □ CHECK □ CASH
□ OTHER (Please specify: _____)