

lois r. steinberg, ph.d. ~ 25 orchard street, suite 204 ~ denville, n.j. 07834
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Credit/Debit Card Payment Consent Form

Payee Name _____
Print: Last First Middle Initial

Name on card if different _____

I authorize Dr. Lois Steinberg to charge my card for professional services as follows:

(Payee Initials)

_____ Charges for missed appointments (no notice: full fee) or for late cancellations (less than 4 hours notice: half fee). (Exceptions may be made in unusual circumstances).

_____ Charges for any unpaid balances after 60 days, unless other prior arrangements have been made.

_____ Charges for which my insurance plan denies services (such as an unmet deductible or charges not covered under the plan).

_____ This visit only, for the amount of \$ _____

_____ All visits over the next _____ months, beginning ____/____/____,

not to exceed \$ _____ in total.

_____ Recurring charges, date(s) of service from ____/____/____ to ____/____/____, not to exceed \$ _____, ____ monthly, ____ semi-monthly, ____ weekly, ____ per visit.

_____ OTHER: _____

Type of card: VISA _____ MASTERCARD _____

Card Number: _____ - _____ - _____ - _____

Expiration Date: ____ / ____ **Security Number** (on back of card): _____

Card holder's billing address for monthly card statements:

Street/apt/floor City State Zip Code

Card holder's signature: _____ **Date:** ____ / ____ / ____