

KATHRYN S. STEINMAN, PSY.D.
Licensed Psychologist

CREDIT CARD AUTHORIZATION
(Please complete even if you prefer to pay by other means)

I, _____, hereby authorize Dr. Kathryn S. Steinman (d/b/a as Kathryn S. Steinman, LLC) to keep this form, my signature on file, and charge my credit card account for any of the following:

1. Initial evaluation, psychotherapy sessions, and other related services;
2. Appointments canceled with less than 24 hours notification; and/or
3. Payments that are 30 days past due.

Name (as it appears on the Credit Card):

VISA MasterCard Discover

Credit Card Number:

Expiration Date: _____ / _____

Credit Card Billing Address:

Street: _____

Apartment Number: _____

City: _____

State: _____

Zip Code: _____

Telephone: _____

I understand the terms of this form and agree that it is valid for five (5) years unless treatment is terminated or I cancel this authorization through written notice to Dr. Kathryn S. Steinman.

Signature

Date

Printed Name