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: ____

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

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