NICOLE RIDOUT, PSY.D.

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CREDIT CARD AUTHORIZATION

I, _____ the undersigned, authorize Dr. Nicole Ridout, Psy.D. to charge my credit card for psychological services. I also authorize Dr. Ridout to charge my credit card if I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify Dr. Ridout's office at least 48 hours in advance for a cancelled appointment, as agreed to in the Informed Consent. In addition, I authorize charges to my credit card for the full amount due on outstanding account balances.

Furthermore, I agree to discuss billing problems with Dr. Ridout before disputing a credit card charge. I understand that Dr. Ridout will be required to disclose information about my attendance and/or cancellation to my credit card company should a dispute arise. This form will be securely stored in a clinical file and, upon request, may be updated at any time.

Card Type: ___Visa ___MasterCard ___Discover

Credit Card Number:_____

Expiration Date: _____ Verification/Security Code:_____

Name (as printed on card): _____

Billing Address:

Street/Apt. #: _____

City:_____ State: _____

Zip Code: _____ - _____ Country: (if not US) _____

Telephone: ( ) _____- _____

Signature: _____Date: _____
(Patient or financially responsible party)