**CREDIT CARD PREAUTHORIZATION FORM**

I authorize Amy Mozolik, PsyD to keep my signature on file and to charge fees, or partial fees, to my Credit Card account for services provided to

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(Print Patient or Client Name)

for the balance of charges not paid by insurance and not to exceed the amount of the full fee as detailed in Dr. Mozolik’s “**OFFICE POLICIES, GENERAL INFORMATION & INFORMED CONSENT**” for each appointment including any fees for missed appointments or cancellations without 24 hour notice.

I agree that:

* if insurance benefits are assigned to Dr. Mozolik, I am still responsible for the total charges incurred regardless of any insurance denial or insurance partial payments unless other arrangements regarding fees have been made. The responsibility will be limited by any participating provider arrangements Dr. Mozolik may have with an insurance company or network.
* this authorization is valid until canceled in writing.
* charges for ongoing services will be posted to my credit card account within a week of each service date.
* If insurance will be billed by Dr. Mozolik, charges for completion of payment after a partial payment by my insurance company will be posted within a month of Dr. Mozolik receiving an Explanation Of Benefits from my insurance company. All charges will appear on my statement as “Amy Mozolik, PsyD”. The amount charged on my account will depend on use of services, insurance arrangements, and agreement now in effect with Dr. Mozolik.
* if I have any problems or questions regarding charges to my account, I will contact Dr. Mozolik for assistance. ***I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Dr. Mozolik.***

Cardholder Name (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address (where your card statements are mailed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Type (circle one): Visa MasterCard

Security Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account # :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exp. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_