FAMILY FOCUSED

GARIN DOUGLAS VICK, PSY.D.

CLINICAL & FORENSIC PSYCHOLOGY

CREDIT CARD AUTHORIZATION FORM

By signing this form, I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered by Dr. Vick, including fees associated with late cancellations (after 24-hours of appointment) or no cancellation of my appointment(s). For your convenience, after visits are discontinued, any remaining balances will be charged to your credit card on file.

By signing this form, I certify that the information provided on this form is true and correct to the best of my knowledge. I am also authorizing Dr. Vick to charge my credit card, listed below, for any of the above noted charges.

I understand that I may revoke this agreement, at any time, by providing a request in writing.

Client's Name: _____ D.O.B.: _____

Card Holder's Name: _____

Card Holder's Address: _____

Visa ___ MC ___ Discover ___ Expiration Date: _____ Zip Code: _____

Account Number: _____3 Digits # on back of card: _____

Signature: _____ Date: _____

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FACP Florida Academy of Collaborative Professionals

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Collaborative Practice Resolving Disputes Respectfully