BARRY J. RICHMAN, MD
PSYCHIATRY

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Credit Card Authorization Form

Name of Patient: _____
Date of Birth

The office requires a credit card to be kept on file as a back-up payment method in the event of bill nonpayment. If, on the prior page, you indicated that you would like to use a credit card to pay for sessions, the card will be charged automatically at time of the session or at the end of the month, depending on your billing plan. Otherwise, cards will only be charged if payments have not been received by their due date.

I am granting permission for Barry J. Richman, M.D. to bill my credit card as per the above parameters.

Name on Credit Card: _____

○ American Express ○ Discover ○ Mastercard ○ Visa

Card Number: _____
Expiration Date: _____
CVV Number (3 or 4 digits): _____
Billing Address: _____
City: _____
State: _____
Zip: _____

Signature: _____