Peter Strisik, Ph.D.
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CREDIT CARD PREAUTHORIZATION FORM

I authorize Dr. Strisik 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 the "Agreement for Psychological Services" for each appointment including any fees for missed appointments or cancellations without 24 hour notice.

I agree that:

- if insurance/employee health benefits are assigned to Dr. Strisik, 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. This responsibility will be limited by any participating provider arrangements Dr. Strisik 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. All charges will appear on my statement as "STRISIK PHD". The amount charged to my account will depend on use of services, insurance arrangements, and agreement now in effect with Dr. Strisik.
- if I have any problems or questions regarding my charges to my account, I will contact Dr. Strisik or the billing manager 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. Strisik.*

Cardholder Name (please print): _____

Billing Address (where card statements are mailed): _____

City: _____ State: _____ Zip: _____

Card Type (circle one): Visa MasterCard

Acct # : _____ Exp. Date: _____ Code: _____

Cardholder Signature: _____ Date: _____