SD Psychiatry and Wellness
Laura Wakil, M.D.

CREDIT CARD AUTHORIZATION

Please complete the following information.

I, _____, am authorizing SD Psychiatry and Wellness, Inc. to
(print name)
charge my credit card for any services rendered as agreed to in the Treatment Consent Form. I also authorize SD Psychiatry and Wellness, Inc. to charge my card in the event I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment at least 24 business hours in advance. Furthermore, for outstanding payments of services rendered, I authorize SD Psychiatry and Wellness, Inc. to charge my credit card for the full amount due. I will not dispute for sessions I have received, or that I have not cancelled less than 24 business hours in advance.

I further authorize SD Psychiatry and Wellness, Inc to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

I acknowledge that I am aware there is a $25 fee for any declined credit card charge.

Card Type:
__ Visa
__ MasterCard

Card #:_____ Expiration Date: _____ CID: _____

Name as Printed on Card: _____

Relationship to patient: _____

Billing Address: _____
(Street, City, State & Zip)

Signature: _____ **Date:** _____
(*client or financially responsible party)*

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 24 business hours in advance, or participation in treatment (eg. appointment or phone session) without payment rendered.