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Credit Card Authorization Form

As a convenience to our clients, we accept most major credit cards and debit cards. You may choose to keep a copy of your credit card on file, to be charged at the time of service in lieu of writing a check.

I, (print name) _____ authorize Dr. Joseph S. Weiss to charge my credit card for services rendered to myself, my family and/or my child.

I understand that (a) my credit card information will be kept on file, (b) my credit card account will be charged at the time of service and, (c) by signing this document, I need not present my credit card at each visit. I further understand that I may terminate this authorization upon no less than **24 hours notice** by sending to Dr. Weiss, at the address above, a letter stating that I elect to terminate this automatic authorization.

Per the practice guidelines provided by Dr. Weiss, I am aware that I will be charged for all appointments, including missed appointments, and those cancelled less than 24 hours in advance. I am also aware that other charges may include but are not limited to: psychological testing and report writing, school consultation, phone consultations/sessions, and book purchases.

Client's Name: _____

Billing Address: _____ ZIPCODE _____

Home phone: _____

Cell phone: _____

Credit Card: VISA__ MASTERCARD__ OTHER_____

Card #: _____ Expiration: ____ / ____

I HEREBY AUTHORIZE MY CREDIT CARD TO BE CHARGED FOR SERVICES PERFORMED AS STATED ABOVE, AND AS OUTLINED IN THE PRACTICE GUIDELINES GIVEN TO ME BY DR. JOSEPH S. WEISS.

Cardholder(s) Signature Date

Printed name _____