Credit Card Authorization Form

I, the undersigned individual, authorized DEREK OTT, M.D. to charge my credit card for sessions attended and for any outstanding balances for previous services rendered. I also authorize Derek Ott, M.D. to charge my credit card in the event that I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify Dr. Ott or his office of my inability to attend a scheduled appointment at least 24 hours in advance, as agreed to in the Patient Information Form. I will not dispute charges for sessions attended or for which I did not give 24 hours notice for cancellation. I further authorize Derek Ott, M.D. to disclose information about my attendance and/or cancellation to my credit card company should there be a charge dispute.

Card Type (please check): ☐ Visa ☐ MasterCard ☐ Discover

Card #: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Exp Date: ☐☐ / ☐☐

Name as Printed on Card:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Verification/Security Code: ☐☐☐

(3-digit code on back by signature line)

Billing Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
(Street)

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(City) (State) (Zip Code)

Patient Name: ______________________________ Date of Birth: ______________

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 only be charged with your approval unless the following conditions apply: participation in treatment without payment rendered, no-show for a scheduled appointment, or cancellation less than 24 hours in advance.

☐ I allow Dr. Ott to automatically bill my credit card at time of service.

☐ I will contact Dr. Ott as to when I may be charged & the amount I will allow to be charged.

☐ I would like Dr. Ott to use this card only ________ time.

Signature: **X** ______________________________________ Date: ______________
(patient or financially responsible party)

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