Gwynne Kohl, PhD
Licensed Psychologist

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AUTHORIZATION FOR CREDIT CARD PAYMENT OF FEES

Patient Name: _____

Responsible Party/Parties: _____

Relationship: _____

Name on Credit Card: _____

Credit Card Number (MC/VISA ONLY): _____

Expiration date: _____ Security code: _____

Billing Address:

_____ Zip Code: _____

I, _____ authorize the payment of fees for _____
(Responsible party) (Patient name)

to Gwynne Kohl, Ph.D. for services rendered. I authorize my credit card to be used to resolve any and all balances in full on my account for individual or consultative charges, missed or forgotten payments, and/or appointments cancelled/no-show within 48 hours as per the Disclosure and Policy Statement. **I understand that payment will be charged the day of service on the credit card I have on file.** I understand that I am required to provide up to date account information on file for regular appointment payments, forgotten payments, missed appointments, and out of office appointments. I also understand that late payments may be subject to an additional late payment fee. Ongoing noncompliance with payment terms may incur collections charges if I do not provide timely payment to resolve my balance.

Signature: _____ Date:_____