Candida Fink MD

4 Stanton Circle
New Rochelle NY 10804
Phone 877-534-1090 Fax 914-560-2106

Credit Card Authorization

Please make sure this form is complete before submitting

For your convenience you may keep a credit card on file with the office. Please note the following:

I understand and accept the terms of the appointment change, cancellation, and no-show policy as outlined in the *Treatment Agreement* – which can be found online at the website or you may request a printed copy. If the credit card is declined I will be expected to supply another credit card number or pay by other means and I understand that I am responsible for payment in full.

Name as it appears on the card: ____

Patient Name (if different than credit card holder): ________________________________

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Billing Address: ____

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Billing Phone Number: ____

Credit Card Type: ☐ **Visa** ☐ **MasterCard** ☐ **AMEX** ☐ **Discover**

Credit Card Number: ____

Security Code: _______________ **Expiration Date:** ___________

Email address: ____

Please initial: It is OK for the office to email me regarding billing matters __________

Cardholder Signature: __________________________________ **Date:**__________________

Please print this page and return it in any of the following ways:

US mail: 12 Parcot Ave New Rochelle NY 10801

Email: carol@finkshrink.com

Fax: 914-560-2106

Or bring to the office during an appointment. Thank you!