Candida Fink MD

12 Parcot Avenue
New Rochelle NY 10801
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): _____

_____

Billing Address: _____

_____

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!