



DR. LAURA BOLOGH, Ph. D.
LICENSED CLINICAL PSYCHOLOGIST

CREDIT CARD AUTHORIZATION FORM

For your convenience , you have the option of having your credit card charged automatically for service renders. If you would like to utilize this option, please complete this form to authorize automatic charges after each session. A receipt will be provided for each visit.

Date: _____

Patient Name: _____

Name on Card: _____

Billing Street Address _____

City _____ State _____

BILLING ZIP CODE: _____

CARD # _____

CVV#(4 numbers on front of AMEX/3 numbers on back of VISA/MC) _____

Expiration Date _____

I, _____, authorize Laura Bologh, Ph.D. to charge my credit card.

Print Name

Signature

All fees are non-refundable. A 3% processing fee is added to all charges. Kindly provide 48 hours notice for cancelations or charges will be applied.