Robin Luband, Psy.D.
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Credit Card Authorization Form

Authorization to Charge Credit Card for Missed Appointments (All Clients Complete*)

If I need to cancel an appointment, I will provide ***24 hour notice (72 hours for weekend or Monday appointments)*** or Dr. Luband may charge my card for the missed appointment. Insurance will not cover payments for missed visits. This authorization will remain in effect until I notify Dr. Luband that I do not want future charges to be authorized or once treatment is terminated.

I, (print) _____authorize Robin Luband, Psy. D., to charge the credit card listed below for ***missed*** office visits. I understand that refunds are not possible.

Please write legibly. Please double check the numbers you've written to ensure correct information is given.

Credit Card Information		
Credit Card Number		
CVC		Expiration Date
Name & Address of Card Holder		
Email address		
You will receive an email receipt each time your card is charged.		

Optional: Recurrent Credit Card Payment

If you prefer to pay for ongoing services by credit card, your credit card will be charged for the session fee and will also be charged the ***credit card processing fee*** associated with this service.

I, (print) _____authorize Robin Luband, Psy. D., to charge the credit card listed above for my office visits. My card will be charged at the end of each week for visits/charges accrued during that time. I understand that refunds are not possible for visits.

***Signature Required Below (All Clients)**

_____ _____

Card Member Signature Date