Hope W. Levin, M.D.
2730 Wilshire Boulevard, Suite 325, Santa Monica, CA 90403
310-494-0108 (phone)
310-943-9012 (fax)

Credit Card Authorization

I, the undersigned individual, authorize Hope W. Levin, M.D. to charge my credit card in the event that I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify Dr. Levin at least 48 business hours in advance for a cancelled appointment, as agreed to in the Office Polices and Treatment Consent Form. Furthermore, for outstanding payments of services rendered, I authorize Dr. Levin to charge my credit card for the full amount due. I agree to not dispute charges for any of these reasons. I further authorize Dr. Levin to disclose information about my attendance and/or cancellation to my credit card company if I dispute a charge. This form will be securely stored in your clinical file and may be updated upon request at any time.

Card Type (please check one):☐Visa ☐MasterCard ☐Discover ☐AMEX

Card #: _____ Expiration Date:_____

Verification/Security Code *(3-digit code on the back of card)*: _____

Name *(as printed on card)*: _____

Billing Address: *(street, city, state & zip)*

_____

Signature: _____

(Patient or financially responsible party)

Date: _____

**Please note, your credit card will not be charged unless one of the following conditions apply:(a) no-show for a scheduled appointment, (b) cancellation less than 48 business hours in advance, or (c) participation in treatment (e.g., appointment or phone session) without payment rendered.*

Please sign and date below if you would like Hope W. Levin, M.D. to bill the above credit card for regularly scheduled appointments.

Signature: _____

(Patient or financially responsible party)

Date: _____