Physician & Healthcare
CONSULTING, LLC

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CREDIT/DEBIT CARD PRE-AUTHORIZATION

If you intend to use a credit/debit card for fees, please complete this page.

I authorize Julie A. Rickard, PhD to keep my signature on file and to charge co-pays, fees, or partial fees, to my credit or debit card account for services provided to:

_____
Patient Name

I understand that this authorization is valid until canceled in writing. I understand that charges for ongoing services will normally be posted to my credit card account within a week of each service date.

I agree that if I have any problems or questions regarding charges to my account, I will contact Julie Rickard, PhD for assistance. I agree that I will not dispute any charges with my credit/debit card company unless I have first attempted to rectify the situation directly with Julie Rickard, PhD and those attempts have failed.

Cardholder Name: _____

Billing Address (where statements are mailed):

_____

City:_____ **State:** _____ **Zip:** _____

Email: _____

Card Type (check one): ☐ **Visa** ☐ **MasterCard**

Account No.: _____

Exp. Date: _____ **CVV-Code:** _____
(The CVV-Code is a 3–4 digit number on the back of your card)

Cardholder Signature: _____ **Date:** _____