Cindy May, Ph.D.
Adolescent and Adult Clinical Psychologist
1101 Dove Street, Ste 155
Newport Beach, CA 92660

Credit Card Authorization

I am granting permission for Cindy May, Ph.D. to bill my credit card for visits. I am also aware that my credit card will be charged for sessions in the event of non-attendance of an appointment not cancelled within 24 business hours of the appointment, or in the event of non-payment of a past due balance, or bill arising from professional services or obligation arising from care of the below mentioned patient.

I agree not to dispute charges for this reason stated above. I further authorize Cindy May, Ph.D. to disclose information regarding my attendance/cancellation to my credit card company if I dispute a charge for these reasons.

Name of Patient: _____

Name on Credit Card: _____

Card Type (please circle one) American Express Discover MasterCard Visa

Card#: _____

Expiration Date: _ _ /_ _ CVV Number _ _ _ _ Billing Zip Code: _____

Signature: _____ Date: _____
(Patient or financially responsible party)

*Please note, your credit card will not be charged unless one of the following conditions apply: (a) no-show for scheduled appointment, (b) cancellation less than 24 hours in advance, or (c) participation in treatment without payment rendered.