

Sven Schild, Ph.D.
CA Licensed Clinical Psychologist (PSY 22339)
EMDRIA Certified EMDR Clinician
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Credit Card Authorization Form

I _____ hereby authorize Sven Schild, Ph.D., Psychologist, Inc., to charge my credit card for services rendered. I understand that all services are final, and that I am solely responsible for charges incurred. The descriptions of charges will read "professional services" on my statement summary. Please initial all that apply:

_____ Please charge my credit card for Dr. Schild's services in the amount of \$_____ which represents my fee, co-pay, and/or combination of deductible plus co-payments on a one-time basis.

_____ Please charge my credit card in the amount of \$_____ for previous balance owed.

_____ Please charge my credit card in the amount of \$_____ per session on an ongoing basis at the time of each session.

A monthly receipt will be mailed to me.

_____ In addition, should I fail to follow the 48-hour cancellation/no-show policy outlined in Dr. Schild's consent agreement, I agree to have my credit card automatically charged for the \$100 no-show/late cancellation fee.

Type of Credit Card: Visa MasterCard Discover Debit/Check card



Name on Card: _____

Card Number: _____

Expiration Date: _____ 3 or 4-digit Security Code: _____

Billing Address: _____

Signature: _____