Michelle G. Ashley, M.D.
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CREDIT CARD CONSENT AND AUTHORIZATION FORM

I hereby authorize Michelle G. Ashley, M.D. to keep my signature on file and automatically charge my credit card for psychiatric appointments as per our agreed upon fee. I agree to pay for services rendered as well as for appointments missed or cancelled less than 24 hours in advance. This agreement will remain in effect unless I revoke such authorization in writing. Charges will appear on my monthly card statement as **ProfessionalCharges.com**. If I have questions about these charges, I agree to contact my provider and if necessary ProfessionalCharges.com via email (info@professionalcharges.com). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

A photocopy or facsimile of this signature is as valid as the original.

Patient's Name: ____

Cardholder's Name: ____

Billing Address: ____

____

_____ MasterCard

_____ Visa

_____ Discover

Account Number: ____

CVV (Security Code): ___________________________

Expiration Date: ___/____

Cardholder's Signature: ____

Date Signed:____/____/_____

ProfessionalCharges.com: 1530 E. Chevy Chase Dr., Ste. 209 Glendale, CA 91206
E-mail: Info@ProfessionalCharges.com