**Melanie Zermeno, MD, Inc**

**4001 W. Alamenda Ave., Suite 102**

**Burbank, CA 91505**

**TEL: (818) 569-0237**

**FAX: (818) 845.5337**

**Credit Card Consent and Authorization Form**

I hereby authorize Melanie Zermeno, M.D.,Inc. 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, appointments for missed or canceled less than 24 business hours in advance. This agreement shall remain in effect unless I revoke such authorization in writing.

**Please complete the information below:**

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| --- |
| Account Type:  Visa  MasterCard  AMEX  Discover  Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cardholder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Account Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_    Billing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

SIGNATURE

DATE