**Melanie Zermeno, MD, Inc**

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

**Burbank, CA 91505**

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**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