

# Osika & Scarano Psychological Services, P.C.

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## Credit Card Authorization

By providing this information you grant us permission to charge your credit card for all services rendered for which you are financially responsible. Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information	
Card Type:	<input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> American Express
Cardholder Name:	(as shown on card)
Card Number:	
Expiration Date:	(mm/yyyy)
Cardholder ZIP Code:	(from credit card billing address)
Security Code:	(3-digit code on reverse of credit card)

I, \_\_\_\_\_, authorize Osika & Scarano Psychological Services, P.C., to charge my credit card above for agreed upon services. I understand that my information will be saved on file for future transactions on my account.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: