



404 W. Boughton Road, Suite A
Bolingbrook, IL 60440

Credit Card Authorization

For internal use only.

I, _____, authorize Marcia S. Gibson PsyD & Associates, P. C. to keep my signature on file and to charge my credit card listed below for:

All copays and coinsurances owed at each session, if applicable.

All patient balances (less than \$250) for services rendered once the claim has been processed by my insurance company.

I understand that Marcia S. Gibson PsyD & Associates, P. C. will contact me by telephone for all patient balances exceeding \$250 prior to charging my card.

I authorize recurring charges for services rendered for the following family members:

Patient Name: _____	DOB: _____

Check One: Visa _____ Master Card _____ Discover _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Expiration Date: _____

CVV: _____ (3 numbers on the back of the card)

Cardholder Signature: _____ Date: _____

Cardholder preferred contact number: _____

I have the right to terminate this authorization at any time and agree to do so by contacting Marcia S. Gibson PsyD & Associates P. C. at (630)759-4000.