Todd E. Ransford, Ph.D.

Licensed Psychologist

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CREDIT CARD AUTHORIZATION ON FILE

I authorize Todd E. Ransford, Ph.D. to keep my signature on file and charge the credit card selected below for the following:

☒ The balance of all charges not paid by insurance within 90 days for all visits and evaluation services for two (2) years from the date of signature below.

☒ Charges for missed appointments or appointments cancelled without 24-hour notice (i.e., $15 per scheduled hour).

☐ My co-payment at the time of service.

☐ All charges at the time of service.

Please check one: ☐ VISA ☐ MasterCard

Credit card number: ______________________________

Exp. Date: ____________

Verification Code (last 3 digits of # found on signature panel on back of card): ______

I assign my insurance benefits to the provider listed above. I understand this form is valid for two (2) years unless I cancel the authorization through written notice to Dr. Ransford.

______________________ ______________________
Cardholder signature Cardholder name (please print)

______________________ ______________________
Client Name Date