Laura L. Darke, Ph.D.
1334 Westwood Blvd. #8
Los Angeles, CA 90024
310-208-1077 Tel.
310-570-1012 Fax

Credit Card Authorization Agreement

I authorize Laura L. Darke, Ph.D., to charge my credit card as follows:

Type of Credit Card: _____Visa _____MasterCard

Name on Card: _____

Credit Card Number: _____

Expiration Date: _____

CVV2 Code (last 3 digits on signature panel): _____

Credit Card Billing Address: _____

Credit Card Billing City, State Zip: _____

_____I would like my credit card to be kept on file and to be used for any scheduled visits.

_____I would like my credit card to be used for unpaid balances but would like the option to use checks in the future.

_____The total amount that I would like charged to my credit card is _____. If you would like your card charged on a specific date, please indicate that date here:_____.

I understand that appointments that are not cancelled with advanced notice of 24 hours, will result in being charged for the appointment.

I understand that my credit card statement will reflect charges from “Laura L. Darke, Ph.D.”

_____
Signature

_____
Patient Name (if the card is not the patients)

Date: _____