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I am granting permission for Dan R. Tzuang M.D. to bill my credit for visits. I am also aware that my credit card will be charged for sessions in the event of non-attendance of an appointment not cancelled within 48 business hours of the appointment, or in the event of non-payment of a past due balance, or bill arising from professional services or obligation arising from care of the below mentioned patient.

I agree not to dispute charges for the reasons stated above. I further authorize Dr. Tzuang to disclose information regarding my attendance/cancellation to my credit card company if I dispute a charge for these reasons.

Name of Patient: _____

Name on Credit Card: _____

American Express Discover Mastercard Visa

Card Number: _____

Expiration Date: _____

CVV Number (3 or 4 digits): _____

Billing Zip Code:_____

Signature: _____

Date: _____