Kristen Smith-Simon, Ph.D.
454 Rolling Ridge Drive, State College PA 16801
Ph. (814) 235-1100 x107 Fax (814) 235-1101

CREDIT CARD AUTHORIZATION

Patient Name: ____ DOB: ________________________

I hereby authorize Kristen Smith-Simon, Ph.D. to keep the following credit card information on file and process it for psychological services rendered in regards to the above-named patient.

I understand that my financial responsibility of charges known at that time will be processed after the end of each month. I will receive a statement summarizing all charges and payments processed that month.

Type of Credit/Debit Card: _____ Visa _____ MasterCard _____ Discover

Card Number: ____

Expiration Date (mm/yy): _____ / _____ 3-Digit Security Code: _________________

Cardholder's Name (print): ____

Billing Address: ____

____ ____________________

Cardholder's Signature Date