Mark W. Wilson, MD
Executive Medical Director
Center for Wise Mind Living
Wise Mind Living Psychiatry
250 W54th Street, Suite 406
New York, New York 10019

CREDIT CARD AUTHORIZATION

It is the policy of this office to keep a credit card on file.

I, _____, hereby authorize Mark W. Wilson, MD, PC to keep this form and my signature on file and charge my credit card the full amount for any of the following:

1. Follow-up appointments (medication management sessions, psychotherapy sessions, parent/school meetings) and other related services
2. Appointments where I do not cancel within 48 hours (two business days) of the scheduled appointment, unless I am able to fill the reserved time
3. Additional and/or future services that I verbally approve

Name (as it appears on the credit card): _____

( ) Visa ( ) MasterCard ( ) American Express ( ) Discover

Credit Card Number: _____ Expiration Date: _____

Credit Card Billing Zip Code: _____ Security Code: _____

I understand the terms of this form and agree that it is valid for five (5) years unless treatment is terminated or I cancel this authorization through written communication with my provider at Mark W. Wilson, MD, PC.

_____ _____
Cardholder's Signature Date Signed

_____
Printed Name