MARK W. WILSON, MD, PC
330 WEST 58TH STREET, SUITE 313
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