CREDIT CARD AUTHORIZATION FORM

This form authorizes Mark D. Parisi, Psy.D. & Associates, P.C. to automatically charge any unpaid account balances that are greater than ninety (90) days past-due once all insurance monies have been paid in full. I understand that, by my signature below, I am authorizing Mark D. Parisi, Psy.D. & Associates, P.C. to charge the credit card listed below for any and all unpaid balances on my account that are greater than ninety (90) days past-due once all insurance monies have been paid in full. I also understand that any inaccurately disputed charge-backs to this credit card will be assessed a fifty ($50.00) fee which will be added to any amounts owed to my account and that my account may be turned over to a Collection Agency for further collections efforts on my delinquent account. This form will be securely stored in your client file and may, at your request, be updated at any time.

I, _____, hereby authorize Mark D. Parisi, Psy.D. & Associates, P.C. to bill my the credit card listed below for any and all unpaid balances on my account that are greater than ninety (90) days past-due once all insurance monies have been paid in full.

Credit Card Type (circle one):

VISA MASTERCARD DISCOVER AMERICAN EXPRESS

CREDIT CARD NO.: _____

CREDIT CARD EXPIRATION DATE: _____

VERIFICATION / SECURITY CODE (3 DIGIT CODE ON BACK OF CARD BY SIGNATURE LINE):
_____

NAME AS PRINTED ON CREDIT CARD:
_____

CREDIT CARD BILLING ADDRESS:
_____

CITY: _____ STATE: _____ ZIP: _____

YOUR SIGNATURE:
_____

PRINTED NAME:
_____

TODAY'S DATE: _____

800 E. Northwest Highway, Suite 106, Mount Prospect, Illinois 60056
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