A M A N D A   L O M A N O V ,   P S Y . D .

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CREDIT CARD CONSENT FORM

I hereby authorize Amanda Lomanov, Psy.D. to charge my Visa/MasterCard/Discover/ American Express/Apple Pay account as indicated below:

An authorized charge will *only* be made under the following circumstances:

- Patient Approval
- Missed Appointments
- Cancellations made less than 24 hours from the time of a scheduled appointment
- Past Due Balances

The fee for service is $_____, as agreed upon between myself and Amanda Lomanov, Psy.D. A processing fee of $_____ (3.2%) will be added to each charge if paying via credit card.

Please check one:

□ Visa
□ MasterCard
□ Discover
□ American Express
□ Apple Pay

Patient Name: ____

Cardholder Name: ____

Cardholder Billing Address:

Street ____

City ________________________ **State**______ **Zipcode** ___________

Account Number: ____

Card Verification # ____

Exp. Date: _______________

Cardholder Signature ____

Date ______________

This authorization is valid for one year unless you cancel the authorization through written notice to Amanda Lomanov, Psy.D.