CENTER FOR ASSESSMENT AND PSYCHOTHERAPY

Credit Card / Recurring Payment Authorization Form

The Center for Assessment and Psychotherapy including the offices of Dr. Mary Murphy, Ph.D., LLC., and Dr. Diana Naddeo, Psy.D., LLC, requires a credit or debit card on file for all services. I Authorize **Dr. Mary Murphy, PhD**:

- to make charges to my Visa, MasterCard, American Express, or other card after each therapy or testing session.

- to charge my card for missed therapy appointments or late cancellation fees (if less than 24 hours notice) in the amount of a full therapy session fee, $250 missed appointment or late cancellation fees (if less than 24 hours notice) for testing appointments, and insufficient check amounts plus insufficient check fee of $30 per bad check.

If I have questions about these charges, I agree to contact **Dr. Mary Murphy, PhD**. I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

If these charges are for someone other than myself (enter person's name and your relationship to them below):

_____ _____

Name **Relationship**

Please complete the information below:

I _____ ***Name (as it appears on credit card)*** authorize **Dr. Mary Murphy, PhD** to to charge my credit card, indicated below, on the day in which I receive my therapy session.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Please make sure the following information is accurate.

Account Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____ CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____

Dr. Mary Murphy, Ph.D., LLC & Dr. Diana Naddeo, Psy.D., LLC
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Newtown, CT 06470