Stephanie T. Ho, Ph.D.
Licensed Psychologist, PSY23000
2725 Jefferson St., Suite 6-103
Carlsbad, CA 92008
760.688.9364

Credit Card Authorization Form

I, _____, a client of Dr. Stephanie T. Ho, understand that I am financially responsible for payment of all services rendered. I hereby authorize Stephanie T. Ho, Ph.D. to keep my signature on file and to charge my credit card account for psychotherapy services and no-show/late cancellation fees, when applicable. These services may include my participation in individual, couples, or family psychotherapy, workshops, or consultation services.

For these services I authorize Stephanie T. Ho, Ph.D. to charge the credit card listed below for outstanding fees in the event that I do not reconcile my invoice/bill within one (1) month of receipt. I understand that if I decide to terminate any of the services and my account is paid up in full, I may withdraw the authorization to charge my credit card in the future provided I communicate revocation of authorization in writing to Stephanie T. Ho, Ph.D.

Client Name: _____

Cardholder's Name (as it appears on the card): _____

Credit Card Billing Address (address that the credit card billing statement is mailed to):

Street Address: _____

Unit or Apt. # (if applicable): _____

City, State, Zip Code: _____

Credit Card Type (please circle): Visa MasterCard AMEX Discover

Credit Card #: _____

Card Verification or Security Code (3-digit number located on back or 4-digit number located on front for AMEX cards: _____

Expiration Date: _____

Signature: _____ Date: _____