

Kathline Colvin, Ph.D.

Founder & Clinical Director
CA License PSY14721

Pacifica Psychological Services

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Credit Card Authorization

I, _____, authorize Kathline Colvin, Ph.D., to charge my credit
(print name)
card in the event that I fail to show for a scheduled appointment, or do not notify Dr. Colvin's
office at least 48 business hours in advance for a cancelled appointment, as agreed to in the
Treatment Consent Form. Furthermore, for outstanding payments of services rendered, I
authorize Dr. Colvin to charge my credit card for the full amount due. I agree not to dispute
charges for any of these reasons. I further authorize Dr. Colvin to disclose information about my
attendance and/or cancellation to my credit card company if I dispute a charge.

Card Type (please check one): Visa, MasterCard

Card #: _____ Expiration Date: _____

Name (as printed on card): _____

Verification/Security Code (3-digit code on the back of card): _____

Billing Address: _____
(Street, City, State & Zip Code)

Signature: _____ Date: _____
(Patient or financially responsible party)

Please sign and date below if you would like Kathline Colvin, Ph.D. to bill the above credit card for regularly scheduled appointments:

Signature: _____ Date: _____

Please note: your credit card will be charged a \$5.00 service fee for each appointment billed to the credit card. Your credit will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 48 business hours in advance, or participation in treatment (eg: appointment or phone session) without payment rendered.

This form will be securely stored in your clinical file and may be updated upon request at any time.