Kathline Colvin, Ph.D.
Founder & Clinical Director
CA License PSY14721

Pacifica Psychological Services
3419 Via Lido, Suite 173 ~ Newport Beach, CA 92663
(714) 593-6900 ~ www.KathlineColvin.com

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 50 minute appointment billed to the credit card. This form will be securely stored in your clinical file and may be updated upon request at any time.