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CREDIT CARD GUARANTY OF PAYMENT FOR MISSED SESSIONS OR LATE CANCELLATIONS:

Upon signing your consent for therapy services, you and I have made a commitment to reserve a particular date and time for therapy appointments. Part of your commitment is to provide at least a 24 hour-notice of cancellation in the event that you cannot attend your scheduled session. If you cancel your session with less than 24 hours notice, you will be charged for the cancellation at the regular therapy session fee of \$_____. This also applies for missed sessions. You are encouraged to reschedule your missed/cancelled session within then next two weeks following such missed/cancelled session.

I understand that Dr. Salazar will be charging me for a missed session or a last minute (less than 24 hours) cancellation through the credit card that I have authorized her to use. I also understand that I am responsible for the payment, and that if for some reason the credit card is cancelled or declined, I will pay the invoice in another way.

I understand that Dr. Salazar uses the credit card company: SQUARE. On my credit card statement the charge will appear with Dr. Salazar's phone number and address as the merchant. I understand that this form is valid unless I cancel the authorization in writing.

Patient Name

Cardholder Name (if different from the patient)

Cardholder Billing Address (including zip code)

Type of Credit Card (Visa, Master Card, or Discover)

Credit Card Number

Security Code

Expiration Date

I authorize Dr. Claudia Salazar to charge my credit card for my missed/cancelled session.

Signature

Date