Nurture Psychiatry & Psychotherapy
Sheela Masifi, MD, MS

CREDIT CARD AUTHORIZATION FORM

I, the undersigned individual, authorize Sheela Masifi, MD, MS to charge my credit card in the event that **I fail to show for a scheduled appointment** or do not notify Dr. Masifi at least **24 business hours (1 business day)** in advance if I cannot make an appointment, as agreed upon in the Office Policies Form. Furthermore, for outstanding payments on services rendered, I authorize Dr. Masifi to charge my credit card for the full amount due. I agree to not dispute charges for any of the above reasons. I further authorize Dr. Masifi to disclose information about my attendance and/or cancellation to my credit card company if I dispute a charge. This form will be securely stored in my clinical file and may be updated by me upon request at any time.

*Please note your credit card **will not be charged** unless one of the following conditions occur:
(a) No Show for a scheduled appointment
(b) Cancellation less than **24 business hours (1 business day**) in advance
(c) Participation in treatment, or services performed, without payment rendered.

Card Type (please select one): Visa MasterCard Discover American Express

Card #: ____________________________________

Expiration Date:_____________________________

Name (as printed on card):____

Verification/Security Code (3-digit code on the back of card or 4 digits on front of AMX):

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Billing Zip Code: (e.g., 90212**)**
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Signature:____

Printed Name:____

Date: _______________________________________