Nancy L. Sack, Ph.D.
Licensed Clinical Psychologist
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(334) 590-8492

Authorization to Charge Credit Card

Please complete all fields.

Patient's Name: _____

Type of Credit Card: ◯ Visa ◯ MC ◯ AMEX ◯ MSA/HSA

Name As It Appears On Credit Card: _____

Credit Card No.: _____

Expiration Date: _____

V-Code (3 digits on back of card of Visa/MC; 4 digits on front of AMEX): _____

Credit Card Billing Address:

Street Address: _____

City: _____ State: _____ Zip: _____

In signing this form I authorize Nancy L. Sack, Ph.D. to charge my credit card, now and in the future, for services (co-pays, co-insurance, failed appointment / late cancellations charges and outstanding balances). This includes charges for missed sessions not cancelled within 24 hours of the appointment time. I understand that if my card declines, Dr. Sack may put my charges through on another day when funds become available. I understand that I may cancel this authorization at any time by contacting Dr. Sack through email notification.

Card Holder's Signature: _____ Date: _____

I authorize Dr. Sack to save this credit card information, my name, and email address to file in the Square payment processor website for future transactions on my account.

Card Holder's Signature: _____ Date: _____