Shannon Gulliver Caspersen, MD

983 Park Avenue

New York, NY 10028

Phone: 646 397 4680

Email: contact@shannoncaspersenmd.com

Credit Card Authorization Form

Name of Patient:_____

The office requires that patients and families keep a credit card on file as a back-up payment method in the event of bill non payment and missed appointments that were not canceled 48 hours in advance of scheduled appointment time. If you indicated on your payment method form that you would like to pay every session by credit card, your card will be charged automatically at the time of the session.

By signing below I grant permission to Shannon Gulliver Caspersen, MD to bill my credit card as per parameters outlined above.

[] Visa []MasterCard
[] American Express []Discover

Name of Card Holder:_____
Card number:_____
Expiration date:_____
CVV number:_____
Billing Address:_____
City:_____State:_____Zip:_____

Signature:_____ Date:_____