David Kan, M.D.
ADDICTION, FORENSIC & GENERAL PSYCHIATRY

1846 Tice Valley Blvd
Walnut Creek, CA 94595

Tel 925-953-2833
www.davidkanmd.com

CREDIT CARD AUTHORIZATION

Patient Name _____

Dr. Kan keeps credit cards on file for all patients. This information is stored securely in your electronic chart. Your credit card will be billed for all charges on the next business day, unless the account is paid by check or cash.

This form is to be completed by patient or guardian.

I, _____, hereby authorize David Kan, M.D. to charge my credit card to pay for my sessions and any other charges I incur for psychiatric treatment. I affirm that I am at least 18 years old and that I am legally authorized to use the credit card account number specified below. I understand that I will be charged for the full amount. I will not dispute sessions that I have received or that I have not cancelled less the 48 hours in advance.

I authorize Dr. Kan to accept updated account information verbally.

If the information below changes, I will let Dr. Kan know immediately.

Card Type (circle one): Visa Mastercard Discover

Account Number _____

Expiration: _____/_____

Security Code (3 or 4 digits) _____

Name (as it appears on the card): _____

Credit Card Billing Address: _____

_____

_____ _____

Signature of Card Holder Date