Cognitive Dynamic Therapy Associates
155 North Craig Street, Suite 170
Pittsburgh, Pennsylvania 15213
412 687-8700 412 687-909
manager@cogdyn.com
www.cogdyn.com

CHARGE AUTHORIZATION FORM

NAME (AS IT APPEARS ON CREDIT CARD): _____

PATIENT'S NAME: _____

ZIP CODE FOR CARDHOLDER:

_____

CREDIT CARD ACCOUNT NUMBER:

_____

EXPIRATION DATE: _____

3 DIGIT SECURITY CODE (BACK OF CARD)

_____

CO-PAY AMOUNT: $_____ OR OTHER AMOUNT $_____

PRE-ARRANGED PAYMENTS AUTHORIZATION AGREEEMENT

I hereby authorize and allow CDTA to charge my credit card account after each office visit for the co-pay listed above. This authority will remain in effect until I notify CDTA in writing otherwise. If I change the credit card specified, I will provide written authorization for the new credit card to CDTA immediately. In addition, I have the right to stop payment of a charge by notifying CDTA before the account is charged. I understand that CDTA reserves the right to terminate this payment plan and/or my participation therein.

Signature _____ Date: _____