FLOWER CITY PSYCHIATRY
(585) 445 8789
THE PARK AT ALLENS CREEK
140 Allens Creek, Suite 200
Rochester, NY 14618

CREDIT CARD PAYMENT AUTHORIZATION

I hereby authorize and direct Flower City Psychiatry PLLC/Allison L Giordano, M.D. to charge my credit card at the then current fee rate for all services that are scheduled for the below named client.

Name of Client: _____
First Last MI

DOB: _____

I understand that I will be responsible for full payment on all scheduled appointments, unless notice of cancellation is received by Flower City Psychiatry LLC/Allison L Giordano, M.D. at least 24 hours in advance of the appointment. I have the right to provide payment in full by other means at the time of service, but I can also opt to have my credit card be charged If I so choose. If there is difficulty in process payment through the specified credit card, I agree to provide payment in full through other payment means. My authorized credit card information is as follows:

Credit Card type: • Visa • Mastercard • Amex • Discover

Name as it appears on the card: _____

Credit Card Number: _____

Credit Card Expiration: _____ CVC Code:

_____

Billing Address:

_____

_____

Street Address City, State & Zip Code

This authorization may be revoked by written notice only. Notice of revocation is effective upon receipt by Flower City Psychiatry LLC/Allison L Giordano, M.D.. Revocation of this agreement does not, in any way, revoke or invalidate credit card transactions that were initiated prior to receipt of the revocation. Once completed, this form may be brought to the office. DO not email credit card information over the internet.

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Name: _____ Date: _____

Signature: _____

Relation (if not signed by the patient): _____