Payment Policy/ Credit Card Authorization Form

Melissa Huy, Ph.D, INC.
4811 Eureka Ave., Suite G-4
Yorba Linda, CA 92886

I _____, hereby authorize Dr. Melissa Huy to keep my signature on file in order to secure my initial appointment and/or charge fees, or partial fees, to my credit or debit card account for services provided to _____ (patient's name) as detailed below:

Fees Patients seen by Dr. Melissa Huy agree to pay $170 per 50 minute therapy session, $220 per 50 minute session for neuropsychological assessment , or the fee of $_____, based on group fees or financial need, which was agreed upon prior to beginning psychotherapy. Any services beyond these standard sessions, such as phone consultation exceeding 15 minutes or excessive paperwork for reports will incur additional fees to be discussed prior to service being provided. If you do not show or fail to cancel your appointment 48-hour in advance, full fee for service will be charged to your card. There will be a convenience fee of $6 to each transaction. You man pay with check or cash with no fee. Cash, checks and credit cards will be accepted as forms of payment. Please note that there is a $25 fee for returned checks. Should you miss a payment, for whatever reason, therapy sessions may be postponed until the full payment is rendered. **You are responsible for the full payment at the time service is provided.**. I understand that fees will be charged to my credit or debit card on the same day that charges are incurred or by the end of the week. As of March 1, 2015 there will be a convenience fee of $6.00 for each credit card transaction, you may pay by cash or check with no fee.

I agree that:

In the event my card becomes invalid I will provide Dr. Huy with a new duly executed credit or debit card authorization form.

This authorization is valid until cancelled in writing via email at DrMelissaHuy@gmail.com or by mail at the above address.

If I have any questions or problems regarding the charges to my account, I will contact Dr. Huy for assistance. I agree that I will not dispute any legitimate charges processed by Dr. Huy.

Card type (circle) MC Visa AMEX FSA (This information is kept in a confidential file that is **locked at all times)**.

Patient's Name_____

Name on Card_____CC number_____

Exp Date___/_____/_____ CVC code (on back of card) _____

Address on file for card_____

City_____State_____Zip_____

I have read, understand and agree to the above fee payment and credit card policy for services provided by Melissa Huy, Ph.D., Licensed Psychologist (PSY18078)

Signature_____Date_____