Northwest Psychiatry

Arvinder Walia, MD

11673 Jollyville Rd. Bldg B, Ste 202

Austin, TX 78759

Tel: (512)-342-7979

Fax: (512)-637-2596

CREDIT CARD AUTHORIZATION FORM

NAME ON THE CARD: _____

TYPE OF CARD: **See staff to provide credit card information…..**

ACCOUNT NAME: _____

DATE OF SERVICE: _____/_____ /_____

DATE OF CREDIT CARD TRANSACTION:_____ AMOUNT TO BE CHARGED:

$_____

PLEASE INITIAL IN SPACE PROVIDED IF YOU ARE AUTHORIZING:

_____ I ALLOW THE OFFICE OF: ARVINDER WALIA, MD TO KEEP THE ABOVE REFERENCE CREDIT CARD ON FILE FOR FUTURE CREDIT CARD TRANSACTIONS.

_____ I ALLOW THE OFFICE OF: ARVINDER WALIA, MD TO RUN ALL FUTURE CREDIT CARD TRANSACTIONS VIA MY VERBAL CONSENT: WHICH INCLUDES DATE & CHARGE AMOUNT; MY CREDIT CARD ON FILE WILL BE CHARGED.

NAME:

_____ _____ DATE: _____/_____/_____

(PRINT) (SIGN)

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Northwest Psychiatry in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.