Susan Ko, PhD

CLINICAL PSYCHOLOGY

CREDIT CARD BILLING AGREEMENT AND AUTHORIZATION FORM

I agree to have my credit card charged at the end of each session. Additionally, IF:
1) I cancel a therapy session without 48 hours notice (barring a real, life-threatening or critical emergency);
2) I fail to show up for a therapy session without 48 hours advance notification (barring a real, life-threatening or critical emergency); or
3) I have an outstanding balance for therapy sessions (e.g., I forgot to bring a method of payment to my therapy session, or had a phone session),
I permit Susan Ko, PhD to bill me for the therapy session(s) by charging my credit card, with the billing information detailed below:

Name on Card: _____

Credit Card #: _____

Expiration Date: _____/_____

Security Code: _____ (3 numbers for Visa/MC, 4 numbers for AMEX)

Billing Address: _____

_____

Billing Zip Code: _____

Email Address: _____

I have read and understand the above agreement and authorize, with my signature below, Susan Ko, PhD to charge my credit card when any of the above conditions are met.

Name (Printed) _____ Date _____

Signature _____

CA LICENSE: PSY20183

1554 S. Sepulveda Blvd, Ste. 215 Los Angeles, CA 90025 P: 310 949 9221 F: 310 756 1235 drko@drsusanko.com