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Neuropsychological Assessment
Psychoeducation Assessment
Forensic Assessment

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Individual/Couples Psychotherapy
Multi-Cultural Identity
HIV Issues

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CREDIT CARD PAYMENT AUTHORIZATION FORM

Date: _____

Name as it appears on Credit Card: _____

Circle One: Visa MasterCard

Account # _____ Exp Date: _____

Billing Address: _____ Zip Code: _____

Please circle one or both below:

I authorized Dr. Sidney Binks to charge current and future rendered services to the above account on a monthly basis.

I authorize Dr. Sidney Binks to charge rendered services to the above account after payment is 30 days past due (60 days from the invoice date).

I authorize Dr. Sidney Binks to charge my past due balance at a rate of \$_____ per month until paid in full.

Signature