**Mark W. Wilson, MD**

**Executive Medical Director**

**Center for Wise Mind Living**

Wise Mind Living Psychiatry

250 West 54th Street, Suite 406

New York, New York 10019

**CREDIT CARD AUTHORIZATION**

It is the policy of this office to keep a credit card on file.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize

Mark W. Wilson, MD, PC to keep this form and my signature on file and charge my credit card the full amount for any of the following:

1. Follow-up appointments (medication management sessions, psychotherapy sessions, parent/school meetings) and other related services
2. Appointments where I do not cancel within 48 hours (two business days) of the scheduled appointment, unless I am able to fill the reserved time
3. Additional and/or future services that I verbally approve

Name (as it appears on the credit card):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) Visa        ( ) MasterCard        ( ) American Express        ( ) Discover

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Expiration Date: \_\_\_\_\_\_\_\_\_\_

Credit Card Billing Zip Code:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Security Code: \_\_\_\_\_\_\_\_\_\_\_

I understand the terms of this form and agree that it is valid for five (5) years unless treatment is terminated or I cancel this authorization through written communication with my provider at Mark W. Wilson, MD, PC.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder’s Signature                    Date Signed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name