THE HAPPINESS PSYCHIATRIST:
SHEENIE AMBARDAR, M.D.
Concierge Telepsychiatry & Teletherapy
(424) 666-8058
www.happinesspsychiatrist.com

CREDIT CARD AUTHORIZATION FORM

I, the undersigned individual, authorize Sheenie Ambardar, M.D. to charge my credit card in the event that **I fail to show for a scheduled appointment** or do not notify Dr. Ambardar at least **48 business hours (2 business days)** in advance if I cannot make an appointment, as agreed upon in the Office Policies Form. Furthermore, for outstanding payments on services rendered, I authorize Dr. Ambardar to charge my credit card for the full amount due. I agree to not dispute charges for any of the above reasons. I further authorize Dr. Ambardar to disclose information about my attendance and/or cancellation to my credit card company if I dispute a charge. This form will be securely stored in my clinical file and may be updated by me upon request at any time.

*Please note your credit card **will not be charged** unless one of the following conditions occur:

(a) No Show for a scheduled appointment
(b) Cancellation less than **48 business hours (2 business days)** in advance
(c) Participation in treatment, or services performed, without payment rendered.

Card Type (please circle one): Visa MasterCard Discover American Express

Card #: _____

Expiration Date:_____

Name (as printed on card):_____

Verification/Security Code (3-digit code on the back of card or 4 digits on front of AMX):

_____

Billing Zip Code: (e.g., 90212**)**

_____

Signature:_____

Date: _____