RAHIM N. RAHEMTULLA, M.D.

Adult, Adolescent, and Child Psychiatry & Psychotherapy

Credit Card Authorization Form

Patient Name: _____
last *first* *middle*

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city *state* *zip*

Date of Birth: _____

Telephone 1: _____ Telephone 2: _____

I authorize Rahim Rahemtulla, MD to bill the Credit or Debit Card below following the conclusion of each clinical visit for the psychiatric assessment, diagnosis, and treatment of the patient above, for missed appointments, or for violations of the practice's cancellation policies.

If you wish to discontinue this authorization at any time, please notify the office at 646.770.3243. This authorization will automatically expire at the termination of treatment. Receipts are supplied (per request) following each clinical visit billed by this authorization.

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220 FIFTH AVENUE, SUITE 300/OFFICE #7, NEW YORK, NY 10001
p 646.770.3243 | f 877.991.8148 | drrahim.nyc