Manely Ghaffari, MD LLC
129 N. 4th Street, Office 1F
Philadelphia, PA 19106

Credit Card Authorization Agreement

Please complete the following information. This form will be securely stored in your (or your child's) clinical file and may be updated upon request at any time.

In the case that you miss or fail to cancel an appointment within 48 hours of the scheduled time, or if a check is returned unpaid you will be charged the full session fee.

I, _____, authorize Dr. Manely Ghaffari to charge my credit card if I fail to show or if I fail to bring my child for a scheduled appointment, or if I do not notify Dr. Ghaffari of my/our inability to attend schedule appointments at least 48 hours in advance. Furthermore, I authorize Dr. Ghaffari to charge my credit card for a session if it was paid for by check and the check was returned for any reason. If I have chosen to keep a credit card on file for payment, I authorize Dr. Ghaffari to charge session fees after each appointment. I will not dispute charges ("charge back") for sessions I have received, appointments I missed or did not cancel with 48 hours' notice as described above. I further authorize Dr. Ghaffari to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

By signing below, I acknowledge that I have read, understood and agreed to the terms outlined above. I authorize Dr. Manely Ghaffari to charge fees as described:

Signature: _____ **Date:** _____
(Patient or responsible party)

Card Type (circle one): VISA MasterCard Discover American Express

Card #: _____ Expiration Date: _____

Name on Card: _____

Verification/Security Code: _____

Billing Address:
_____

City: _____State: _____ Zip: _____