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[www.beverlydavispsychologist.com](http://www.beverlydavispsychologist.com)

Dear Patient,

We continue to look for ways to make your health care experience as hassle-free as possible. One of the things we can do is minimize paperwork, mail and additional fees associated with receiving payment from you .

In order to do that, we have implemented a new process that allows us to charge your credit card for any balance remaining on your account. Your authorization to charge your credit card is ONLY for any outstanding balance that is identified as patient responsibility. Your authorization shall remain in effect for two years from the date below.

Please be assured that the Privacy Policy of this practice complies fully with all federal and state privacy protection laws and regulations. Protection of patient privacy is of paramount importance to our office and applies to your financial information as well as your medical history.

We will notify you once payment has been processed via email.

Email Address (required) \_\_\_\_\_

Card Holder Name \_\_\_\_\_

Billing Address \_\_\_\_\_

\_\_\_\_\_

Card Type (circle): VISA      MASTERCARD      DISCOVER      AMEX

Credit Card# \_\_\_\_\_

Expiration date: \_\_\_\_\_ CCID# \_\_\_\_\_

I hereby authorize Dr. Beverly Davis to charge my credit card as listed above for any outstanding balance for services rendered by this office and shown to be patient responsibility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Use Only:

Patient Name: \_\_\_\_\_ Acct# \_\_\_\_\_

Employee Completing Transaction: \_\_\_\_\_ Date: \_\_\_\_\_