DILEK WISE, INC.
1458 Campbell Rd. Ste.250A Houston, TX 77055

Dilek Wise, PhD, LMFT
www.dilekwise.org

CREDIT CARD INFORMATION IS REQUIRED.

Your credit card information is kept STRICTLY CONFIDENTIAL.

I understand & agree that: "**I will be charged $165.00 to my credit card below when I miss an appointment or cancel it within the 48 hours of my originally reserved appointment time. I also give Dr. Wise my full consent to charge any unpaid balance amount of a claim –which is originally filed to my insurance panel but denied for any reason."** In either case, you will receive a receipt of payment via email or mail. It is your responsibility to cancel or update your credit card authorization/information in writing. Invalid credit card information on file, at the time of charge, is subject to $30.00 additional fee.

Credit Card Authorization

"I , ______________________________, authorize Dr. Dilek Wise, LMFT to charge $165.00 to my credit card below when I miss or cancel my appointment without giving 48hrs. in-advance notice." **Please SIGN HERE:** ______________________________

"I , ________________________________, authorize Dr. Dilek Wise, LMFT to charge the total unpaid balance in my account after the insurance reimbursements are credited to my credit card below." **Please SIGN HERE:** ______________________________

"I , _______________________________, authorize Dr. Dilek Wise, LMFT to charge the total balance of my Skype/Online consultation to my credit card below." **Please SIGN HERE:** ______________________________

Name as Shown on the card: ____________________________________

MC/ Visa No: __________________________________ Exp.Date: ___/____ Verification ID# __ __ __

Discover No: ________________________________ Exp.Date: ___/____ Verification ID# __ __ __ __

Credit Card Billing Zip Code:_______________

Authorization Date: ____/_____/________