The Anxiety and Stress Disorders Institute of Maryland, LLP

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PATIENT CREDIT CARD APPROVAL

(NOT TO BE A PART OF PATIENT'S MEDICAL RECORD)

I, ________________________, GIVE MY THERAPIST, ___________________________, MY

APPROVAL TO USE MY CREDIT CARD NUMBER FOR PROCESSING MY PATIENT SESSIONS WITH

MY THERAPIST THROUGH THE ANXIETY AND STRESS DISORDERS INSTITUTE OF MARYLAND, LLP.

MY NAME ON CREDIT CARD:_____________________________

Print Name Clearly

Type of card: Visa ____ Master Card ____ (We do not accept Discover Card)

CARD NUMBER: _______________________________ 3 DIGIT CODE ________
(on back of card)

EXPIRATION DATE: ____________________

MY ADDRESS /ZIP CODE ASSOCIATED WITH THIS CARD:

____

MY WRITTEN SIGNATURE: ____

INITIAL: ______ I HAVE RECEIVED A COPY OF THIS FORM

DATE: _________