

**Psychological Solutions, LLC
Credit Card Authorization Form**

The purpose of e-mail and telephonic (telephone) communication outside of a therapy session has been explained to me fully. I have had the opportunity to ask questions regarding same. I have been freely offered to schedule appointments using the mental health benefits of my insurance company for face to face contact. I have freely opted to obtain access to therapy-related services in a modality that is not reimbursable by my health insurance, namely e-mail and telephone communications.

The standard hourly rate is \$160 per hour and is billed at a minimum of 1 unit as follows:

0-15 Minutes = 1 unit = \$40.00
16-30 Minutes = 2 units= \$80.00
31-45 Minutes = 3 units= \$120.00
46-60 Minutes = 4 units= \$160.00

The fee begins upon opening of the e-mail or beginning of phone conversation and ends at the time the e-mail is sent or the phone conversation terminates. Dr. Weisberg uses a timer and keeps records of all such transactions. These are available upon request.

I understand NO charges will be made to my card unless I use these services. It is my responsibility to update my records should my card be cancelled or expire. Further, in the unlikely event that I would dispute these charges, I will not take this action without FIRST contacting Psychological Solutions and attempting to resolve the matter.

Therefore, I am authorizing Dr. Richard Weisberg and Psychological Solutions, LLC to charge my credit card according to the fee schedule as detailed above.

Credit Card Information

Credit Card (circle one): MasterCard Visa

Type of Card (circle one): Credit Debit

Credit Card Number: _____

Credit Card Expiration Date: _____(e.g., MM/YYYY)

3 Digit Security Code: _____ (located on back of card above signature; Last 3 digits)

Signature of Cardholder

Date

Cardholder Name (Printed)